



UNIVERSITY OF
LIVERPOOL

**Developing the Intervention Evidence Base for
Children and Young People who have
Experienced Domestic Violence and Abuse**

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the University of Liverpool for the degree of Doctor in
Philosophy

By

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ABSTRACT

Domestic violence and abuse (DVA) is a global health problem and it is widely established that children and young people can be negatively affected by experiencing DVA (Potter & Feder, 2017). The current evidence base for interventions delivered in the United Kingdom (UK) targeted at children who have experienced DVA is underdeveloped and inconclusive; few qualitative studies have explored the experiences of those who have provided or received such interventions (Howarth et al., 2016). This thesis explored two research questions: RQ1: *How do intervention recipients and providers perceive interventions targeted at children and young people who have experienced DVA?* RQ2: *How can the evidence base be improved for interventions targeted at children and young people who have experienced DVA?* Study 1 aimed to assess the effectiveness of three psychotherapeutic interventions by analysing evaluation data and pre- and post- intervention outcomes. The limited data available meant that the aim of Study 1 was not achieved. In response, Study 2 qualitatively examined the experiences of individuals who receive and deliver interventions targeted at children who have experienced DVA and aimed to identify the difficulties of demonstrating intervention effectiveness. Study 2 comprised 35 semi-structured in-depth interviews with the following intervention stakeholders: children (n=3), parents (n=6) and intervention providers (n=12). The interviews were analysed using Thematic Analysis (Braun & Clarke, 2006). Six themes were developed: *Divergent perceptions about an intervention's purpose; The timing of an intervention; The appropriate length of an intervention; The significance of who delivers an intervention; Barriers to evaluating interventions; and The contribution of qualitative methods in examining intervention outcomes.* The results and lessons learned from Studies 1 and 2 are presented in three meta-themes: (1) The value of the voice of the child; (2) A lack of appreciation for divergent views; (3) The impact of organisational context. This thesis makes invaluable contributions for the future development of the evidence base for interventions targeted at children who have experienced DVA. This thesis advocates that the voices of children and young people must be fundamental to developing and evaluating interventions that are available to them. As intervention stakeholders can view an intervention from different angles this can influence intervention engagement and outcomes. Therefore, understanding why perceptions about interventions differ is paramount to reconcile. Finally, the organisational context in which interventions are provided may hinder joint-working, and the delivery and robust evaluation of interventions, subsequently

hampering the evidence base of interventions. The limitations are discussed and implications for theory, policy, practice and research are presented.

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Chapter 1: Introduction

This thesis initially aimed to investigate the effectiveness of interventions delivered by an organisation in the United Kingdom (UK), for children and young people who had experienced domestic violence and abuse (DVA). This was to be achieved through analysing evaluation data. However, the data collected was not as robust as had first been thought. As a result, the initial aims of the study could not be met. Subsequently, a qualitative study was developed in order to understand the interventions in the lives of the people who both delivered and received them. To set up the wider context of the thesis, this chapter introduces the topic of DVA, defines key terms that will be used throughout the thesis, discusses the literature relating to children and DVA, and highlights the importance of demonstrating the effectiveness of interventions. At the end of the chapter, an overview of the thesis will be presented.

1.1 Introduction

DVA is a violation of human rights and is a global public health concern (Potter & Feder, 2017). After several decades of feminist practice and activism, the elimination of DVA is a global ambition of the United Nations (European Commission, 2010). Historically, DVA has been viewed as a private and hidden matter (García-Moreno et al., 2015) which should be addressed within the family home, although what constitutes a ‘family’ has changed over time (Toulemon, 2016). DVA is a gendered crime that disproportionately affects women (Potter & Feder, 2017). At least one in four adult women (27.1%) and one in six adult men (13.2%) in England and Wales are recognised as ‘victims’ of DVA (ONS, 2016; Woodhouse & Dempsey, 2016). Although a gendered crime, DVA can be perpetrated by women against men, and also occurs in same-sex relationships (FRA, 2014; Hester et al., 2015). A UK study proposed that 29.5% of children and young people have lived with DVA during their lifetime, and in any one year approximately 5.7 percent of children and young people will experience living with DVA (Radford, Corral, Bradley, & Fisher, 2013). These statistics provide the context for this thesis.

1.2 Defining domestic violence and abuse

Defining DVA is not straightforward, as its complexity is intertwined with different constructions of violence which are culturally and historically specific (Hester, 2004). A range of terms have been used to refer to DVA, including, ‘battering’, ‘family violence’, ‘spousal abuse’, ‘intimate partner violence’ and ‘interpersonal violence’, reflecting a range of theoretical debates surrounding this topic (Devaney & Lazenbatt, 2016). In the United States of America (USA), familial approaches to terminology have been adopted, with terms such as ‘common couple violence’, ‘patriarchal violence’, ‘intimate partner violence’, ‘interpersonal violence’, or ‘spousal violence’ being used (Johnson, 1995; Pahl, 1985). Overall, there has been a lack of clarity about what levels of violence and abuse these terms encompass (Hester, 2013).

The term ‘domestic violence’ was developed in light of feminist research and activism during the 1970s, and this term is now widely used in UK policy (Radford & Hester, 2006). It has been argued that the term ‘domestic’ helpfully differentiates between ‘stranger’ violence, and violence which can occur within any relationship and takes place behind the closed doors of the domestic setting (Mooney, 2000; Stanley, 2011). However, it has been suggested that the use of the word ‘domestic’ implies that the individuals involved, live together and that the violence only takes place in the home, overlooking how violence often continues after couples separate (Barter, 2009; Harne & Radford, 2008; Humphreys & Thiara, 2003; Monckton-Smith, Williams, & Mullane, 2014; Walklate, 1992). The use of the word ‘violence’ has also been criticised due to the narrow meaning it conveys, positioning physical violence as holding greater significance than other forms of violence (Hague & Malos, 2005; Kelly, 1988; Mooney, 2000; Mullender, 1996; Stark, 2007). An alternative term used in Scotland, is ‘domestic abuse’. Whilst the word ‘abuse’ may better represent different forms of domestic violence, use of the term ‘abuse’ has been criticised as it does not clearly depict the range of non-physical forms of violence that can occur (Devaney & Lazenbatt, 2016).

Adopted in the 1994 United Nations General Assembly Declaration on the ‘Elimination of Violence Against Women’, the term ‘violence against women’ was used by radical and socialist feminist groups. However, this term emphasised a specific focus on adult women being the ‘victims’ without encompassing the experiences of children and young people (Harne & Radford, 2008). Acknowledging children’s experiences, the UK policy agenda has recently moved to *“ending violence against women and girls”* (Home Office, 2010).

In March 2013, the UK Home Office made changes to the definition of DVA, which acknowledge the experiences of younger people, and introduced the notion of controlling and coercive behaviour. DVA was defined as:

“Any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality. This can encompass, but is not limited to, the following types of abuse: psychological; physical; sexual; financial; emotional” (Home Office, 2013, p.2).

The revised definition of DVA contains important changes which begin to unpick the complexity of behaviours involved in DVA. The adjustment in recognising those aged 16 and above has meant that the DVA definition does not only encompass adults (individuals over 18 years). The previous definition, which only included individuals aged 18 years and above, was inconsistent in the UK context in which the age of consent for sex and marriage is 16 years. The former definition of DVA was also limited to an incident-based approach, trivialising patterns of controlling behaviours and strategies of intimation, isolation and control which have a cumulative impact (Stark, 2007). In the current definition of DVA, the terms ‘control’ and ‘coercion’ are explicitly defined:

“Controlling behaviour is: a range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour.

Coercive behaviour is: an act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim” (Home Office, 2013, p.2).

The inclusion of control and psychological abuse in the legal definition of DVA provides an important opportunity to acknowledge that DVA is not limited to a gender or ethnic group, and is inclusive of family members who could be, mother or father, son or daughter, brother, sister, grandparents, or directly related in-law or step family (Devaney & Lazenbatt, 2016). Thus, the current UK definition of DVA goes some way to recognising the cumulative impact of behavioural patterns and broadens the scope of behaviours that can be considered abusive. This shift in legislation has moved away from traditional ideas that limit DVA to being physical violence alone. For the purpose of inclusivity, and in line with the UK governments’ current terminology, the term, ‘domestic violence and abuse’ (DVA) will be used throughout this thesis.

1.3 Perpetrators and ‘victim/survivors’

There are further definitions to be discussed with regard to how individuals experience DVA. Throughout this thesis, the term ‘perpetrator’ will be used when referring to an individual who has committed acts of DVA. It should be noted that perpetrators of DVA may also have experienced DVA themselves, and therefore the use of the term ‘perpetrator’ is not intended to overlook this.

When considering how to refer to those who have experienced DVA, debates concerning the use of the terms, ‘victim’ and ‘survivor’ are ongoing (Dobash & Dobash, 1992; Gondolf & Fisher, 1988; Hague, Harvey, & Willis, 2012; Johnson, 1995; Radford & Hester, 2006). Both terms have been recognised as ‘problematic’ due to the cultural implications associated with each term (Williamson, 2000). Recognising an individual as a ‘victim’ has been viewed as promoting the idea of helplessness and dependency amongst those who have experienced DVA (Gondolf & Fisher, 1988; Walker, 1979; 1984). Other authors suggest that the term ‘victim’ is paternalistic and fails to recognise the agency of individuals (Lamb, 1999). Whilst the term ‘survivor’ can be perceived as more empowering, as an individual may have ‘survived’ the adversity of DVA, it has been criticised as failing to convey the experience of being abused as well as the ongoing impacts of DVA (Williamson & Serna, 2018). Some authors have argued that the terms ‘victim’ and ‘survivor’ do not adequately represent the experiences of DVA (Kelly, 1988; Radford & Hester, 2006) and that forcing individuals to choose between the labels of ‘victim’ or ‘survivor’ can devalue their agency and limit how meaning can be given to their experiences (Nissim-Sabat, 2009; Schott, 2012). It has recently been argued that the use of labels in the context of DVA further entrenches the DVA in the identity of individuals (Williamson & Serna, 2018). Subsequently, it can be difficult for the individual to escape this identity. Therefore, it is important to allow for and respect self-labelling, as well as respect lack of labelling.

In this thesis, I use the term ‘victim/survivor’ when referring to individuals who have experienced DVA, to reflect how victimisation and survival can be both present in the experience and aftermath of DVA (Downes, Kelly, & Westmarland, 2014). However, there are instances when the term ‘victim’ is used when making specific references to legislation which uses this terminology.

1.4 Children and young people

The existing research within the field of DVA refers to those under 18 years of age using a range of terms such as, ‘children’, ‘young people’ ‘adolescents’ and ‘older children’. These terms are often used without specifying which ages these particular terms refer to. For example, the term ‘adolescent’ is used only occasionally due to a lack of consensus about categorising the beginning and end points of the sub-stages of early, middle and late adolescence in terms of specific age groups (Coleman, 2011; Goldenring & Rosen, 2004; Kaplan, 2004). With regard to law and policy (HM Government, 2015), the term ‘child’ refers to a person who is under the age of 18 years in accordance with the definition contained in the United Nations Convention on the Rights of the Child (Office of the High Commissioner for Human Rights, 1989) and the Children Acts (1989; 2004). The terms ‘children’, and ‘young people’ will be used interchangeably throughout this thesis when referring to any individual who is under the age of 18 years.

1.5 Children and DVA

Historically children have been overlooked regarding DVA (Powell & Murray, 2008), and in the early 1990s, scholars in the UK and in North America argued that too little attention had been given to children who lived with DVA (Jaffe, Wolfe, & Wilson, 1990; Mullender & Morley, 1994; Peled, 1993; 1996). There is now, however, a substantial body of research which recognises that children can experience DVA in a range of ways (Campo, 2015; Carlson, 2000). DVA may be experienced by children observing and overhearing incidents of DVA or being forced to watch or participate in acts of DVA (Holden, 2003). Their involvement has been such that children have been reported to assume personal responsibility for DVA (Hester & Radford, 1996; Parkinson & Humphreys, 1998), often because DVA has taken place within the context of parents arguing about the child (Fantuzzo, Boruch, Beriama, Atkins, & Marcus, 1997). It has also been acknowledged that children can be verbally or physically assaulted when ‘witnessing’ DVA (Hester, Pearson, Harwin, & Abrahams, 2007; Holden, 2003) and that children have been reported to physically intervene to try and prevent DVA from occurring (Holden, 2003; Mullender et al., 2002). The Adoption and Children Act (2002) defines DVA as, a form of harm to children, recognising the ‘damaging’ implications of children living in DVA households (Stanley, Miller, Richardson Foster, & Thomson, 2010).

It has been recognised that some children experience DVA by being included in the dynamics of the intimate dyad between the perpetrator and the victim/survivor, which is recognised as ‘triangulation’ (Callaghan, Alexander, Sixsmith, & Fellin, 2018a). Triangulation is often associated with conflict and distress because children are implored to take sides and this can result in a shift of alliances against a parent and even siblings (Dallos & Vetere, 2012). The effects of triangulation on children can lead to long-term psychological distress through scapegoating, split loyalties and role inversions such as parentification, whereby the non-abusive parent relies on the child for support and inappropriately discusses their relationship with the perpetrator (Amato & Afifi, 2006; Buehler & Welsh, 2009; Cooper & Vetere, 2008; Stephens, 1999).

There can be difficulties in discerning between DVA and child abuse, as violence and intimidation are often directed to children as well as adults (Dallos & Vetere, 2012). This is particularly pertinent when abuse of the child is used by the perpetrator as a strategy in order to control the adult victim/survivor (Hester et al., 2007). It has been acknowledged that in families where DVA exists, children are more likely to be directly targeted as ‘victims’ themselves (Devaney, 2008; Humphreys, 2007; Jouriles, McDonald, Slep, Heyman, & Garrido, 2008). It has also been observed that child domestic homicide is often preceded by adult DVA, which has led to writers suggesting an association between the two (Bourget, Grace, & Whitehurst, 2007; Coordinated Action Against Domestic Abuse, CAADA, 2014a; Jaffe, Campbell, Hamilton, & Juodis, 2012).

1.5.1 How children ‘experience’ DVA

The way in which experiences of DVA are defined and referenced warrants discussion. To reflect the ways in which children can experience DVA, children have been described as being ‘exposed’ to DVA (Edleson & Nissley, 2011; Holden, 2003), whilst others have referred to them as ‘witnesses’ of DVA (Jaffe et al., 1990). Whilst these terms may be used to encompass children observing direct violence or threatening behaviour, overhearing it, seeing physical injuries and observing the emotional consequences of DVA, such terms fail to capture how children are directly involved in DVA (Buckley, Holt, & Whelan, 2007; Devaney, 2015; Swanston, Bowyer, & Vetere, 2014).

Throughout the thesis, I refer to children and young people as having personally ‘experienced’ DVA, advocating the view that terms such as ‘witnessing’ or being ‘exposed’ to DVA undermine their experiences (Irwin, Waugh, & Bonner, 2006). The term ‘experience’ conveys the involvement of children and young people in DVA as

being central and intimate rather than peripheral and passive (Stanley, 2011). This acknowledges the fact that children and young people have lived through DVA, have a capacity for finding ways of coping, and are able to reflect on their experiences (Alexander, Callaghan, Fellin, & Sixsmith, 2016; Callaghan & Alexander 2015; Callaghan, Alexander, & Fellin, 2016a; Callaghan, Alexander, Sixsmith, & Fellin, 2016b; 2018a; Callaghan, Fellin, Alexander, Papathanassiou, & Mavrou, 2017a; Cater, 2007; Fusco & Fantuzzo, 2009; Houghton, 2015; Katz, 2016; Øverlien, 2014; 2017; Øverlien & Hydén 2009; Swanston et al., 2014).

1.5.2 The implications of children experiencing DVA

There is now an extensive body of evidence that demonstrates the multitude of ways in which DVA can impact children and young people (Chan & Yeung, 2009; Edleson, 1999; Fowler & Chanmugam, 2007; Holt, Buckley, & Whelan, 2008; Kitzmann Gaylord, Holt, & Kenny, 2003; Onyskiw, 2003; Wolfe, Crooks, Lee, McIntyre-Smith, & Jaffe, 2003). It is well established that children living with DVA are at greater risk of experiencing neglect, physical and/or sexual abuse compared to those who are not (Brandon et al., 2012; Hamby, Finkelhor, Turner, & Ormrod, 2010; Radford & Hester, 2006). It has been argued that experiencing DVA is at least as impactful as being targeted directly as a ‘victim’ of DVA (Moylan et al., 2010; Sousa et al., 2011).

A prevalence study conducted in the UK by the National Society for the Prevention of Cruelty to Children (NSPCC) found that, children and young people who experienced DVA were between almost three and four and a half times more likely to experience physical violence and neglect from a caregiver, in comparison to those who had not experienced DVA (Radford et al., 2011). In comparison to their peers who have not experienced DVA, children who have can experience significantly more frequent behavioural and emotional difficulties (Meltzer, Doos, Vostanis, Ford, & Goodman, 2009). A series of meta-analyses have indicated that experiencing DVA in childhood is associated with children subsequently experiencing a range of behavioural, emotional, and social problems (Evans, Davies, & DiLillo, 2008; Kitzmann et al., 2003; Wolfe et al., 2003). This has included experiencing educational challenges (Byrne & Taylor, 2007), interpersonal difficulties in future intimate relationships and friendships (Black, Sussman, & Unger, 2010; Ehrensaft et al., 2003; Siegel, 2013), a greater risk of bullying or being bullied (Baldry, 2003; Lepistö, Luukkaala, & Paavilainen, 2011), and increased vulnerability to other abuses during their lifetime (Finkelhor, Ormrod, & Turner, 2009; Turner, Finkelhor, & Ormrod, 2010); It has also been recognised that this population of children and young people are more likely to experience mental health difficulties

during their life (Meltzer et al., 2009; Mezey, Bacchus, Bewley, & White, 2005) and experience neurological difficulties because of the severe level of stress that is associated with DVA (Anda et al., 2006; Choi, Jeong, Polcari, Rohan, & Teicher, 2012; Koenen, Moffitt, Caspi, Taylor, & Purcell, 2003). Researchers have observed that infants, even as young as one year old, can also be negatively affected by DVA (Øverlien, 2010). For example, DeJonghe, Bogat, Levendosky, von Eye, & Davidson (2005) reported that one-year-old infants who had experienced DVA were more likely to display distress in response to verbal conflict compared to those who had not experienced DVA.

It is important to recognise that children can react differently in light of experiencing DVA. Whilst some children may ‘externalise’ their feelings through exhibiting aggressive or anti-social behaviour, others can ‘internalise’ their behaviours, which may lead to higher levels of depression, anxiety and trauma symptoms (Devaney, 2015). Whilst it has been reported that the impact of DVA on both boys and girls is similar with regard to internalising behaviours, boys have been reported as being more likely to display externalising behaviours compared to girls (Evans et al., 2008).

A substantial body of research has explored the effects of trauma and post-traumatic stress disorder (PTSD) amongst children who have experienced DVA, and the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) diagnosis of PTSD has been used to evaluate negative outcomes for children who experience DVA (Øverlien, 2009). A number of studies have observed that children who experience DVA are at increased risk of suffering from PTSD (Griffing et al., 2006; Jarvis, Gordon, & Novaco 2005; Lehmann, 1997). The concept of trauma has often been used to describe a wide range of problems that are not captured by the more limited PTSD category (Price-Robertson, Rush, Wall, & Higgins, 2013; Wall & Quadara, 2014). Trauma in this context is associated with “*sustained or cumulative exposure to abusive interpersonal relationships in childhood*” (Campo, 2015, p. 7). Amongst those experiencing trauma, a range of psychological and behavioural symptoms can be evident, such as experiencing changes in attention span, consciousness or self-perception, and an inability to manage internal emotions (Bateman, Henderson, & Kezelman, 2013; Margolin & Vickerman, 2011; Wall & Quadara, 2014). It has also been observed that children who experience DVA over a sustained period of time may experience trauma symptoms and PTSD. If left untreated, this can have long lasting effects on children’s development, behaviour and wellbeing, which can include anxiety, depression, eating disorders, and substance abuse (Jaffe, Wolfe, & Campbell, 2012).

1.5.3 DVA and the mother-child relationship

One particular implication of experiencing DVA which has been extensively explored in the literature is the harm imposed on the mother-child relationship, and how this can impact a child's development and future relationships (Campo, 2015). Based on the notion that secure attachment relationships are important for healthy development and adult functioning, Lannert et al. (2014) proposed a relational model of trauma, whereby the ability of caregivers to shield their child from experiencing trauma became compromised by their own experiences of DVA. This led to children developing insecure attachments to their caregivers. In Howell's (2011) review of the literature, which specifically focused on pre-school children who had experienced DVA, it was proposed that younger children's experience of DVA was associated with developing physical and psychological symptoms. As these children spent a greater proportion of time with their mothers compared to school-age children, they lacked the opportunity to benefit from the potential buffering effects provided by the school environment. In such cases, children relied on self-protective behaviours such as withdrawal, anger and aggression, and had developmental difficulties as a result of having poor emotion regulation or struggling to recognise others' emotions.

Whilst it has been argued that a mother's ability to care for her children may be negatively affected by her experiences of DVA (Thiara & Harrison, 2016), DVA has also been conceptualised as an 'attack' on the mother-child relationship, whereby perpetrators directly and indirectly undermine the mother-child relationship as a tactic of control and abuse (Humphreys, Thiara, Sharp, & Jones, 2015; Morris, Humphreys, & Hegarty 2015; Mullender et al., 2002; Thiara & Humphreys, 2015). As the mother-child relationship can often continue to be undermined or even worsen following separation from the perpetrator, this has suggested that separation from the perpetrator of DVA does not guarantee the protection or resolution of the mother-child relationship (Bagshaw et al., 2010; Katz, 2014; Morris et al., 2015; Radford & Hester, 2015; Stanley, 2011). However, children and mothers have been recognised as playing an active role in repairing the mother-child relationship, by being 'recovery-promoters' for one another. In interviews with 15 children and 15 mothers, one recent study observed how children and mothers used a number of successful techniques to promote each other's long-term recoveries and well-being (Katz, 2016). These included reassuring one another about the past, present and future, and rebuilding each other's confidence

Emphasis in the DVA literature has been placed on ‘good’ mothers determining the state of children’s mental health and well-being. Consequently, mothers can also be seen as ‘failures’ in their parenting, which subsequently presents a deficit model of parenting (Bancroft & Silverman, 2002; Lapierre, 2008). This ‘mother-blaming’ discourse not only positions the mother as responsible for their children’s mental health but can shift the focus away from male violence and its implications for women and children (Callaghan, 2015; Callaghan, Fellin & Warner-Gale, 2016c). Although many studies have assessed the mother-child relationship in the context of DVA, a lack of attention has been given to exploring the father-child relationship (Guille, 2004; Humphreys et al., 2015). However, in the limited number of studies examining this, it has been observed that fathers who are perpetrators of DVA often do not recognise the implications DVA can have for their children (Holt, 2015; Rothman, Mandel, & Silverman, 2008).

1.5.4 Limitations of research exploring how DVA can affect children

Whilst there is an extensive body of research that has examined how DVA can impact children, this research can generally be critiqued in light of the methods used (Stanley, 2011). Research studies have predominantly relied on collecting data from mothers and children in refuges, which does not necessarily represent the wider population of those who have experienced DVA (Gewirtz & Edleson, 2007). Furthermore, research has largely depended on mothers’ perceptions about the impact of DVA on their child, but what is reported can vary depending on whether the mother or child has reported the impacts (Chan & Yeung, 2009). There are also difficulties in establishing cause and effect relationships between children’s experiences of DVA and its implications. Children may experience DVA alongside other risk factors, which may increase the risk of negative outcomes, and the convergence of these factors may be difficult to separate from the effects of DVA (DeBoard-Lucas & Grych, 2011; Holt et al., 2008). Such risk factors may include parental substance abuse, poverty, other forms of child abuse and neglect, poor mental health and social isolation (Bromfield, Lamont, Parker, & Horsfall, 2010; Gewirtz & Edleson, 2007; Goddard & Bedi, 2010; Higgins, 2004).

1.5.5 The ‘intergenerational transmission of violence’

The association between experiencing DVA in childhood and experiencing it later in life as the perpetrator or victim/survivor has often been explained by the theory of ‘intergenerational transmission of violence’, or, the ‘intergenerational cycle of abuse’, deriving from social learning theory (Ehrensaft et al., 2003; Kalmuss, 1984; Siegel,

2013). Early studies that examined aggression exhibited by children indicated that violence could be a socially learned behaviour (Bandura, 1971; 1973; 1986), suggesting an association between having a history of observing violence and children enacting it in subsequent generations. The intergenerational transmission of violence theory suggests that a child who grows up in a home affected by DVA, passively absorbs the violence they have observed and goes on to repeat the violence, as they learn 'violence' as a habitual response to conflict (Black et al., 2010). The theory has proposed two types of modelling to explain how 'violence' is transmitted (Kalmuss, 1984). The first is 'generalised' modelling, whereby observing aggression in childhood communicates its acceptability to the child and increases the likelihood of family aggression in subsequent generations. The second is 'specific' modelling, whereby individuals imitate the specific type of aggression that they have observed.

There has been considerable debate regarding the extent to which children's experiences of DVA alone can exclusively determine their future involvement in a DVA relationship. Whilst practitioners, policy makers and researchers have often identified children's experiences of DVA as being one of the strongest predictors of a child's later involvement in a DVA relationship either as a victim/survivor or perpetrator, findings to support this theory have been inconsistent (Black et al., 2010; Haselschwerdt, Savasuk-Luxton, Hlavaty, 2017). It has been recognized that not all children who experience DVA become a perpetrator or victim/survivor of DVA, and not all perpetrators of DVA have necessarily experienced DVA in childhood (Casey, Beadnell, & Lindhorst, 2009). In studies where there have been correlations between experiencing DVA in childhood and future involvement in a DVA relationship, these children have been reported as having experienced a childhood characterised by other risk factors which could also influence the likelihood of their involvement in future DVA relationships. These risk factors include, socio-economic disadvantage, poor parental mental health, parental substance abuse and child abuse (Fergusson, Boden, & Horwood, 2006; Fulu et al., 2013; Higgins, 2004).

It has been acknowledged that the construction of abusive cycles 'dooms' children to becoming future perpetrators, offering them no alternative narrative to that of perpetration or victimisation (Callaghan, Fellin, Mavrou, Alexander, & Sixsmith, 2017b). This construction of the child has been reported by children to invoke anxiety and fear of being 'caught' in the 'cycle' (Callaghan & Alexander, 2015). This particular representation of children has translated into child protection discourses, in which professionals who support this group of children have focused on helplessness and

intergenerational transmission, rather than acknowledging children's existing coping strategies in response to experiencing DVA (Callaghan et al., 2016a; 2016b; 2018a; Callaghan, Alexander, & Fellin, 2018b). In nine focus groups with 39 parents and carers, it was reported that whilst parents/carers experienced a constant 'battle' for their child to access services, the services that were more readily available supported parenting and assisted with the management of children's behaviour, in comparison to addressing the emotional 'fallout' of living in abusive households (Callaghan & Alexander, 2015). The nature of available services therefore seems to reflect how children are viewed in light of the intergenerational transmission of violence theory.

1.5.6 Children's resilience

Whilst the existing research on how children are affected by experiencing DVA is important to acknowledge, it has been argued that research should also focus on identifying the factors which lead to resilience in children (De-Board-Lucas & Grych, 2011; Heugten & Wilson, 2008; Humphreys & Houghton, 2008). The broader concept of resilience can be defined as, *"the process of effectively negotiating, adapting to, or managing significant sources of stress or trauma. Assets and resources within the individual, their life and environment facilitate this capacity for adaptation or 'bouncing back' in the face of adversity"* (Windle, 2011, p.163). When referring to resilience in the context of DVA, this refers to responding positively and recovering from experiencing DVA (Anderson, Renner, & Danis, 2012).

A range of factors have been proposed as contributing to children's resilience in light of experiencing DVA (Campo, Kaspiw, Tayton, & Moore, 2014). These include the child's relationship with their primary caregiver, the age of the child when they experienced DVA, on the basis that older children could more easily engage in developing supportive relationships outside the family home leading to resilience, children's peer support and engagement in school activities, children being able to escape the family home, and children receiving an adequate response or intervention following DVA (Gewirtz & Edleson, 2007; Heugten & Wilson, 2008; Holt et al., 2008; Howell, 2011; Humphreys & Houghton, 2008; Mullender et al., 2002; Richards, 2011; Thompson & Trice-Black, 2012; Willis et al., 2010; Yates, 2013). Having a secure attachment to a non-violent parent or other significant carer has been consistently cited as an important 'protective' factor in mitigating the trauma and distress associated with children's experiences of DVA (Holt et al., 2008). In light of this, it has been recommended that practitioners and providers of services should invest in supporting children who have experienced DVA by providing interventions that seek to repair and

promote these positive attachments, either between a child and their non-abusive parent, or another significant adult such as a grandparent (Devaney, 2015).

The concept of resilience has been constructed as both a property or characteristic of children, being part of their personality, cognitive ability or social skills, as well as something which is produced or mediated by how mothers cope (Flach et al., 2011; Gewirtz & Edleson, 2007; Howell, 2011; Humphreys, 2003; Martinez-Torteya, Anne Bogat, von Eye, & Levendosky, 2009). However, perceiving resilience as a characteristic, skill or outcome that is usually absent from children who have experienced DVA can risk over-pathologising this population of children (Humphreys & Houghton, 2008). It should be noted that much of the literature on children's resilience in experiencing DVA is based on data derived quantitatively. This does not encourage children to articulate their personal understanding of resilience, and often fails to directly engage with the voices of children (Callaghan & Alexander, 2015).

In contrast, recent research which has engaged with the voice of the child has framed children's resilience strategies as demonstrating their agency in how they manage, live with and recover from DVA (Alexander et al., 2016; Callaghan et al., 2016a; 2016b; 2018a; 2018b; Cooper & Vetere, 2008; Katz, 2016; Swanston et al., 2014; Ugazio, 2013). Children have been observed to find ways of coping creatively and with agency, however these ways of coping may be perceived by others as being 'dysfunctional'. The idea of 'paradoxical resilience' has been proposed whereby, *"children's experiences of woundedness and coping intertwine, and responses that may appear to an external professional to be 'pathological' or problematic often have features of a kind of paradoxical resilience"* (Callaghan & Alexander, 2015, p.94). However, observing the diverse forms of children's coping has been argued to challenge the assumption of a *"single normative developmental trajectory for children's well-being and functioning"* (Callaghan et al., 2018b, p.96).

1.5.7 The silent voices of children

Failing to talk to children about their personal lived experiences of DVA presents children who experience DVA as silent and presents them as too vulnerable to share their accounts (Callaghan, 2015; Eriksson & Näsman, 2012; Mullender et al., 2002; Øverlien, 2009). The adult-informed DVA literature therefore presents a partial account of children's experiences of DVA (Callaghan et al., 2016b; Øverlien, 2009). As studies often rely on quantitative measures that are completed by adults, the voices of children are seldom represented in a body of literature that claims to be about them (Callaghan, 2015; Eriksson, 2012; Eriksson & Näsman, 2012; Overlien, 2009).

Children's status and visibility in DVA literature has been slow to develop within the research community (Øverlien & Holt, 2017). Studies exploring the prevalence and impact of DVA on children have largely involved eliciting the views of adults, such as mothers, refuge workers and other professionals working in the DVA arena (Hazen, Connelly, Kelleher, Barth, & Landsverk 2006; Øverlien & Holt, 2017). While it is undoubtedly evident that children can be affected by their experiences of DVA, excluding them from research on the basis that they are too damaged, denies the child the right to articulate and reflect on their own experiences (Callaghan et al., 2018a). At the same time, relying primarily on the voices of adults can misrepresent the experiences of children (Scott, 2008).

In part, the focus on the adult voice may stem from a concern about children's capacity to reliably express their views (Day, Carey, & Surgenor, 2006) or that the child may have been unaware of the violence and should be sheltered from it (McGee, 2000), thus presuming an assumption of childhood innocence (Burman, 2016). There has also been concern that a child's involvement in research would re-traumatise them and result in further harm as they share the memories of their experiences (Alderson & Morrow, 2011; Morris, Hegarty, & Humphreys, 2012; Øverlien & Holt, 2017). Although re-traumatisation has been reported in the literature (Devries, Naker, Monteath-van Dok, Milligan, & Shirley, 2016), studies have also provided limited support for the theory of re-traumatisation. In a telephone interview study with 4503 young people aged 10 to 17 years, which explored young people's possible experiences of DVA, participants were asked whether answering the questions upset them (Finkelhor, Vanderminden, Turner, Hamby, & Shattuck, 2014). The results indicated that 4.5 percent of children reported being upset, and 0.8 percent reported being 'pretty' or 'very' upset, and more children who had experienced DVA reported being upset compared to those who had not. Whilst three percent of young people said that they would not participate in the study again, this reason was usually due to the length of the study, rather than the discussion of DVA content specifically. It has been acknowledged that both children and adults experience sharing their accounts of DVA through research as being therapeutic (Downes et al., 2014). However, it remains paramount that the ethical challenges of engaging children and young people in sensitive research are appropriately considered and managed (Øverlien & Holt, 2017).

It has been reported that professionals can be reluctant to encourage children to talk about their experiences, which they and other service providers feel poorly equipped to manage (Lombard, 2015). Although gatekeepers may prevent a child from receiving

the invitation to participate in DVA related research because of wanting to protect a child, this can become problematic when many children are not given the opportunity to make a choice about their participation (Øverlien & Holt, 2017). Thus, the direct experiences of children are often excluded by adults elevating the protection of the child over their agency (Hanson, 2016; Houghton, 2017). The professional practice of obscuring the voices of children can also send a message to children that their voices are not valued; together with the disempowering nature of DVA, this further subordinates children's voices to those of adults (Callaghan et al., 2018b; Vetere & Cooper, 2005). This has also been evident in children's decisions about making disclosures of DVA, where their decision has been reported to be influenced by their previous experiences of being taken seriously, and whether or not their accounts have been dismissed or disbelieved (Callaghan et al., 2017b).

1.5.8 Implications for policy and practice

Peled (1996; 1998) argued that children and young people should not be presented as 'secondary victims' of DVA, but rather as 'victims' in their own right. Despite the substantial body of evidence that demonstrates the ways in which children are affected as a result of experiencing DVA, children generally continue to be remain largely conceptualised as witnesses of DVA, as opposed to 'victims' who 'experience' DVA (Callaghan & Alexander, 2015). At present, not all children and young people share the same legal status as a 'victim' in DVA legislation in the UK, as the aforementioned Home Office (2013) definition of DVA has excluded those under 16 years from being recognised as 'victims', with the exception of teenage dating violence. The Istanbul Convention on the Prevention of Violence Against Women and Girls has presented children in a similar position, by excluding children from being recognised as 'victims' of DVA and emphasising the intimate 'adult' dyad of DVA (Callaghan et al., 2017b). Therefore, the current needs of children are considered within their representation as 'witnesses' of DVA (Children Act, HM Government, 2004). This can obscure children's representation and voice in policy and in professional discourse, raising questions about how children's experiences of DVA are perceived and the extent to which legal definitions can engage with their experiences (Callaghan & Alexander, 2015). Current UK policy frameworks present children's experiences of DVA as secondary, and without recognising their personal agency in DVA, thus being insufficient in responding to children who experience DVA (Callaghan et al., 2018a).

It has been proposed that including children in the DVA legislation as 'victims' may provide children and young people with a stronger platform from which to make

their voices heard (Callaghan et al., 2018a), and that the new Home Office (2015) coercive control legislation could provide an opportunity to recognise children's experiences of coercive control as direct 'victims'. Although coercive control is now included in legislation as DVA, it has been argued that the traditional physical incident model, which focuses on physical incidents of violence alone, still dominates (Katz, 2016), and children remain absent from legal definitions of DVA. The recent HM Government's consultation, 'Transforming the response of Domestic Abuse', which began on 8 March 2018 and ended on 31 May 2018, provided further opportunities to discuss children and DVA in light of legislation and policy. As part of this consultation, discussions have been made concerning how children are educated about DVA, and how they can be protected and supported. Whilst the consultation welcomed discussions concerning the inclusion of children under 16 years as 'victims' in the statutory definition of DVA, the consultation report presented reservations in doing so, out of concern that this change this would blur lines between DVA and child abuse.

The complex relationship between the different policy responses of family law, child protection, and DVA and their respective effects on children has been widely discussed (Hester, 2011; Humphreys, 2008; Powell & Murray, 2008). Hester (2011) described the relationship between these sectors as the 'Three Planet Model', which comprised, the 'domestic violence planet', the 'child protection planet' and the 'child contact planet'. The 'domestic violence planet' involves those organisations working specifically with DVA, such as refuges and providers of advocacy that have developed with the adult victim/survivor as their central focus, and criminal and civil justice agencies that intervene with perpetrators. The 'child protection planet' comprises safeguarding and child protection services, placing the child as the key focus of their work. The 'child contact' planet involves professionals such as family court advisors and other professionals focusing on parents, their residence and contact arrangements with children. As each sector has their own histories, philosophies, laws and sets of professionals, Hester (2011) argued that this could lead to difficulties in responding to incidents of DVA that involve children and can even lead to unsafe situations for the children. However, it has been suggested that collaboration between these sectors would lead to an improvement in the outcomes for this group of children through having clearer governance structures and systems (Campo et al., 2014; Healey & Humphreys, 2013).

According to the aforementioned HM Government's (2018) consultation, 'Transforming the response of Domestic Abuse', it has been proposed that multi-agency

safeguarding arrangements led by three safeguarding partners (local authorities, chief officers of police, and clinical commissioning groups), will replace Local Safeguarding Children Boards. As highlighted in the consultation “...*this will involve local areas to work together to develop stronger, bespoke working arrangements between the three key agencies and other relevant agencies, we expect to see an improvement in the quality of inter-agency work to safeguard children. The new legislation will provide additional powers to secure effective participation from key agencies and agree plans to strengthen information sharing*” (HM Government, 2018, p.27).

It should be acknowledged that there has been an increased awareness of DVA in 'mainstream' services (Humphreys & Stanley, 2006; Stanley, 1997; Rivett & Kelly, 2006) and organisations working with women who have experienced DVA. This has led to a focus on developing services and expertise in working with children who have experienced DVA (Ball, 1990; Debbonaire, 1994; Hague, Kelly, Malos, & Mullender, 1996; Hague, Mullender, Kelly, & Malos, 2000; Higgins, 1994). Community-based DVA services for victim/survivors and children who have experienced DVA have evolved substantially since the 1970s (Saathoff & Stoffel, 1999). Grass roots efforts have led to the development of services which have aimed to provide safety and support to women and their children who had experienced DVA. However, it has been argued that the services available specifically for children who have experienced DVA are often positioned as ‘additional’ to the main services offered to adult ‘victims’ by specialist shelters, social services and the police rather than children being the primary targets of service interventions (Callaghan et al., 2018a). The implication of support services for children being ‘additional’ to specialist DVA services is that when services for women have stopped, this has been reflected in a discontinuation of support for their child. Moreover, in cases where support services for women have focused on risk management, once the family has been viewed as being ‘safe’, the limited services that were available for the children have usually dissolved (Callaghan et al., 2018a). The discontinuation of support for children is concerning, given that children’s emotional and social difficulties either continue or often only emerge once the family have ‘resettled’ post-separation from the perpetrator (Morrison, 2015). Furthermore, only nine percent of children in the UK have access to Child and Adolescent Mental Health Services (CAMHS) for mid- to long-term support (CAADA, 2014b).

As emerging research has explored children's experiences of DVA and has emphasised the importance of protecting the mother-child relationship, this has led to services being ‘pressured’ to directly address issues around mother-child relationships

(Humphreys, Mullender, Thiara, & Skamballis, 2006a; Rabenstein & Lehmann, 2000). Moreover, many interventions have emphasised teaching children social skills, anger management (Holmes, 2013), and emotion coaching (Katz & Windecker-Nelson, 2006). However, it could be argued that the approaches underpinning these interventions may adopt the assumption that children are at risk of pathology and need to be trained in order to compensate for their presumed ‘deficits’ (Callaghan et al., 2017c). In light of how children are presented as somewhat reactive behavioural ‘units’ there may be challenges in training professionals and volunteers to provide emotionally and socially focused support to children, through which they are viewed as responsive and agentic beings (Callaghan et al., 2017c).

1.5.9 Listening to the voice of the child

As stated in the United Nations Convention on the Rights of the Child (UNCRC, 1989), all children have the right to make their voices heard in matters that concern them (Article 12), whilst also having the right to protection from harm and exploitation (Article 19) (Øverlien & Holt, 2017). Reflecting the philosophical underpinnings of the UNCRC, the theoretical development of the new sociology of childhood proposes a shift from viewing children as objects of enquiry (Øverlien & Holt, 2017; Powell & Smith, 2009) to those who can influence “*adult-centred socially constructed meanings of citizenship*” (Bacon & Frankel, 2014, p.22). In this context, children should be regarded as competent social actors with the right to participate in and to be listened to regarding issues which affect them (Åkerlund & Gottzén, 2017; Prout & James, 1990). The shift towards adopting child-centred methods and the growth in childhood research studies have impacted DVA research, which traditionally regarded children’s right to protection as having greater importance than their right to participate in research (Qvortrup, Coraso, & Honig, 2009). However, prioritising both children’s rights to protection and participation now increasingly underscores studies that explore experiences of DVA directly from children and young people (Åkerlund & Sandberg, 2017). This demonstrates an increasing acknowledgment of children reflecting on and sharing their experiences in light of their right to be heard (Einarsdottir, Dockett, & Perry, 2009; Skelton, 2008).

This shift has coincided with the broader notion of researching *with* children in inter-related fields (Jaffe, Poisson, & Cunningham 2001; Morris, Hegarty, & Humphreys, 2012). Examples of this include researchers consulting the views of children who have participated in family court proceedings (Bagshaw et al., 2010) or have experienced parental divorce (Butler, Scanlon, Robinson, & Murch, 2003; Smart,

2006), as well as recruiting children and young people in health (Morris et al., 2012) and education settings (Carroll-Lind, Chapman, & Raskauskas., 2011). However, concerns still remain about establishing the balance between children's right to participate and their right to protection in both research and policy-making (Houghton, 2015; Powell, Fitzgerald, Taylor, & Graham, 2012; Woodhead, 2010).

A small yet growing body of literature emphasises the importance of directly listening to the voices of children and young people who have experienced DVA (Callaghan & Alexander, 2015; Callaghan et al., 2016a; 2016b; 2016c; Cater & Øverlien 2014; Eriksson, 2009; Eriksson & Näsman, 2012; Katz, 2016; Mullender, 2006; Mullender et al., 2002; Øverlien, 2010; 2012; Øverlien & Hydén, 2009). Research with this population of children has emerged, particularly in the UK and the Nordic countries (Åkerlund & Gottzén, 2017). This literature positions children and young people who have lived through and 'experienced' DVA, as having a capacity for agency and ability to reflect on their experiences, challenging previous conceptions of them as passive and silent (Alexander et al., 2016; Callaghan & Alexander, 2015; Callaghan et al., 2016a; 2016b; 2016c; Cater, 2007; Fusco & Fantuzzo, 2009; Houghton, 2015; Katz, 2016; Øverlien, 2014; 2017; Øverlien & Hydén, 2009; Swanston et al., 2014).

Studies have acknowledged that children and young people are not only actively involved in their experiences of DVA, but they can take an active role in research. Øverlien and Hydén (2009) observed that children and young people aged between 12 and 15 years, could narrate their experiences of DVA and reflect upon how they managed their experiences through their own capacity for coping. In a study of younger children (aged between four and seven years), it was observed that as well as children describing their experiences, they actively managed the interview and regulated their emotions throughout the research, for example, when they made disclosures of DVA (Evang & Øverlien, 2014).

In order to uphold both children's right to be heard (Article 12, UNCRC) and children's right to protection (Article 19, UNCRC), research *with* children and not *on* them requires careful ethical consideration and the development of practices that are sensitive to the rights and needs of children (Cater & Øverlien, 2014; Ellonen & Pösö, 2011). Within the context of clinical research, it has been argued that there is a need to protect children *through* research rather than protecting children and young people *from* their involvement in research (Sammons, Wright, Young, & Farsides, 2016). This is ensured through developing ethical and scientifically robust ways of conducting research with children (Modi et al., 2014), which is also important to consider in non-clinical

contexts. The increasing interest in conducting qualitative research with children who have experienced DVA calls for ongoing discussion about the general ethics of non-clinical qualitative research with this population (Cater & Øverlien, 2014).

The adult-focused definition of DVA and adult-informed literature has led to children and young people's accounts of their own experiences being overlooked in the context of DVA services (Callaghan et al., 2018a; Katz, 2016). This may have had implications for the extent to which children's voices have been used to inform the planning, delivery, and evaluation of services, through which their perspectives would make an invaluable contribution (Mullender et al., 2002; Slay & Penny, 2013; Walsh, Wilson, Baines, & Martin, 2012). Thus, prioritising children's right to be heard as well as their right to protection could have invaluable implications for policy and practice. One example of this working in practice is the Voice Against Violence (VAV) national advisory group based in Scotland (UK). This consists of eight young people who have experienced DVA and homelessness alongside their mothers. The VAV group have made significant changes to the service, research and policy landscape in Scotland in relation to children seeking help and solutions for practice, serving in the role of young expert advisors to government, and having regular access to senior politicians (Houghton, 2017). This group have received specialist support and have been actively involved in research advisory groups and political activism, influencing service evaluation and training as well as policy (Houghton, 2008a; 2008b). By challenging the aforementioned 'deficit' constructions of children and young people that tend to dominate the DVA literature and reflecting the developing shift towards recognising children's voice, power, and agency, the VAV group exemplifies how young people can claim their right to and role in shaping political action. VAV provides an excellent example of what is made possible by political investment in young people's participation in enhancing national policy-making (Houghton, 2017), presenting a challenge as to whether adults can engage with young participants in a way that is empowering (Malone & Hartung, 2010), and respects young people's expertise as equal to, albeit different from, that of adults (Houghton, 2015).

So far, this chapter has introduced the literature concerning children and DVA and has identified implications for policy and practice. Over-emphasising the negative impacts of DVA on children can lead to viewing children as damaged and can undermine their own existing strategies for managing their experiences. Arising from the intention to protect children, the literature on DVA is heavily informed by the voices of adults, rather than the direct voices of children. However, it is encouraging that

emerging research has begun to recognise both children's right to protection from harm and right to participation in matters that concern them, which can have invaluable implications for developing practice and policy if acted upon.

1.6 Approaches to preventing DVA

Children's experiences of DVA have been defined as a form of child maltreatment (MacMillan et al., 2009) requiring a health-care and societal response (Howarth et al., 2016). It has been argued that the most direct way of preventing the negative effects of DVA on children and young people would be to prevent or end DVA itself (Wathen & MacMillan, 2013). Although Chapter 2 critically reviews the literature concerning the evidence base of interventions for children who have experienced DVA, it is important at this stage in the thesis to outline the three broad types of services that aim to prevent DVA (Early Intervention Foundation, 2014).

i) Universal services (primary prevention)

'Universal services', which are also known as 'primary prevention', aim to address DVA before it has occurred (Bentovim, Cox, Bingley Miller, & Pizzey, 2009). These services are often provided to young people through educational or school-based campaigns and aim to influence views about DVA, embedding an understanding of healthy relationships in children and young people before DVA occurs.

ii) Early Intervention (secondary prevention)

'Early Intervention' or 'secondary prevention' is concerned with identifying and intervening in the situations of children and young people who are displaying particular behaviours or have risk factors associated with an increased risk of experiencing DVA. This approach may involve collaborative working between child protection agencies and DVA service providers, as well as with educational or health providers, whereby professionals are equipped to identify DVA.

iii) Late prevention (tertiary prevention)

'Late' or 'tertiary prevention' involves intervening after DVA has been identified. These services involve advocacy approaches and support services for victim/survivors, safeguarding for children who have experienced DVA, and intervention programmes that aim to reduce the recidivism of perpetrators. In comparison to universal and early intervention services, late prevention services are the most common type of service available to children and young people in the UK (Howarth et al., 2016).

1.7 Evidencing the effectiveness of interventions

There has been increasing demand for a rigorous evidence base to demonstrate the effectiveness of interventions in reducing and preventing DVA (Gondolf, 2012; Sullivan, 2011). In competing for diminishing resources, third sector providers may need to have more robust evidence of intervention effectiveness and cost-effectiveness (Downes et al., 2014). Rossi, Freeman, and Lipsey (1999) have defined evaluation as *“the use of social research procedures to systematically investigate the effectiveness of social intervention programmes”* (p. 4). Social intervention programmes are understood as planned, organised, and ongoing activities, carried out for the purpose of improving a specific social condition. DVA intervention programmes are one such example of a social intervention (Bowen & Gilchrist, 2004).

Evaluation studies typically seek to identify the aims of an intervention programme, identify measurable indicators of achievement, collect data which demonstrates these indicators, and assess what was achieved against the original aims of the intervention (Weiss, 1972; 1998). As well as establishing whether an intervention is effective, understanding why and how an intervention is effective may constitute equally important questions (Davidoff, Dixon-Woods, Leviton, & Michie, 2015; Weiss, 1998). This is particularly important when considering the replication of interventions in different contexts (Hoffmann et al., 2014).

Seen as the ‘gold standard’ in evaluating ‘treatment effects of an intervention, randomised controlled trials (RCTs) are placed at the top of the research evidence hierarchy whilst cross-sectional studies, case studies, and expert opinion are placed at the lower end (Gartlehner, Hanson, Nissman, Lohr, & Carey, 2006). RCTs comprise at least one test treatment and a comparator treatment, the randomisation of treatment allocation and the measurement of outcomes (Meinert, 2012). RCTs provide a strong method for investigating the effectiveness of complex interventions. Complex interventions contain several interacting components and have several dimensions of complexity, such as the range of possible outcomes, their variability in the target population, and the degree to which an intervention can be tailored and adapted (Craig et al., 2008). As will be critically discussed in Chapter 2, there is recognition of the pressing need for well-designed studies and trials that examine the effectiveness of complex interventions (Feder et al., 2011; Howarth et al., 2015). It has been argued that evidencing intervention effectiveness should be restricted to RCTs or studies that

involve a comparison group, in order to isolate the effect of the intervention on outcomes (Macdonald, 1999).

In light of this, the role of qualitative research in intervention evaluation is often overlooked. However, qualitative research has been identified as having a number of critical roles in demonstrating intervention effectiveness. One role is that it can help to inform the selection of measured outcomes, by collecting the views of key intervention stakeholders, which can contribute to the design of future trials to assess intervention effectiveness (Howarth et al., 2016). This is important as careful decisions need to be made about which outcomes are measured, as these will be fundamental for intervention decision-making and funding (Williamson et al., 2012). In addition to measuring outcomes that are important to service recipients, identifying outcomes that resonate with the priorities of policymakers and service providers can ensure that effective interventions are not overlooked in such a way that they would not be commissioned or implemented (Hoagwood et al., 2012). In addition to deciding which outcomes should be measured, qualitative research can also facilitate decisions regarding how an outcome is measured, and who reports the outcome such as the patient or service user, a clinician or practitioner, or a combination of individuals (Velentgas, Dreyer, Nourjah, Smith, & Torchia, 2013). Qualitative research also plays an important role in informing the development of interventions, the development of clinical trials, and providing explanations of reported outcomes (Dixon-Woods, Agarwal, Jones, Young, & Sutton, 2005).

1.8 Thesis structure and aims

It is important at this stage to provide an overview of the thesis. This introductory chapter has aimed to introduce the background context to the thesis. It has discussed definitions and terminology that will be used throughout the thesis, introduced literature relating to children and DVA and its implications for policy and practice, highlighted general approaches to preventing DVA, and introduced the importance of demonstrating intervention effectiveness.

Chapter 2 critically reviews what is known about the evidence base for interventions targeted at children and young people who have already experienced DVA. The underdeveloped and inconclusive evidence base is discussed in light of the limitations associated with several factors: the research study designs and methods used to explore intervention effectiveness; heterogeneity in outcomes measured across studies which are usually adult-informed; and a paucity of research that has identified the

structural, practical and cultural factors hindering the development of the evidence base. Chapter 2 also emphasises the importance of qualitative research in examining the perspectives of those who receive and deliver the interventions, an area that has not been adequately explored. Chapter 2 also presents the key research questions that this thesis aimed to answer.

Chapter 3 presents Study 1 as a standalone piece. Study 1 aimed to demonstrate the effectiveness of three interventions provided by a DVA organisation to children and young people who had experienced DVA. Due to the challenges and limitations which arose from the study, the effectiveness of the interventions could not be established. Chapter 3 presents anonymised details about the DVA organisation and three interventions that were explored, in order to provide the context for the subsequent study that was developed. Study 1 is presented in the thesis because the lessons learned from the study make valuable contributions to understanding the difficulties of evidencing intervention effectiveness, which are further explored in the Discussion.

Chapter 4 introduces Study 2, presenting its theoretical background and justifying the methods used to explore its aims. The chapter also discusses the sampling and recruitment of participants, ethical considerations in relation to the participants and my own welfare as the researcher, how the qualitative data were analysed, my personal reflections on researching with the participants in the context of DVA, and the limitations of the study. The aims of Study 2 were:

- i) To examine the experiences of individuals who receive and deliver interventions targeted at children and young people who have experienced DVA
- ii) To identify the difficulties of demonstrating the effectiveness of interventions targeted at children and young people who have experienced DVA

Chapters 5, 6, 7 and 8 present the qualitative themes from Study 2. Chapter 5 presents Theme 1- ‘Divergent perceptions about an intervention’s purpose’, discussing the range of perceptions that participants held about the interventions. Whilst the role of an intervention was usually unclear to children, the parents and intervention providers viewed interventions as contributing to developing normative constructions of childhood, and their views were expressed in a variety of ways.

Chapter 6 presents Theme 2- ‘The timing of an intervention’, Theme 3- ‘The appropriate length of an intervention’, and Theme 4 - ‘The significance of who delivers an intervention’. These themes demonstrate the range of views had about critical

components of intervention delivery, which have important implications for how interventions are designed and implemented.

Chapter 7 presents Theme 5- ‘Barriers to evaluating interventions’, contextualising the difficulties of evidencing intervention effectiveness. The challenges were associated with limited intervention stakeholder engagement levels in evaluation, limitations and complexities associated with the tools used to evidence outcomes, the limited resources available to ensure robust evaluation, and difficulties in joint-working amongst intervention providers. These barriers made it difficult to evaluate the interventions and also help to contextualise some of the research difficulties experienced in Study 1.

Chapter 8 presents Theme 6- ‘The contribution of qualitative methods in examining outcomes’. This theme demonstrates how the qualitative interviews in Study 2 facilitated an exploration of intervention outcomes in ways that quantitative measures were unable to. As a result, the qualitative narratives highlighted the importance of prioritising the voice of the child, understanding that outcomes are contextually situated, and identifying unanticipated outcomes of an intervention that were not accounted for.

Chapter 9, the Discussion, synthesises the results from Study 2 and the lessons learned from Study 1. The chapter critically discusses these with reference to wider literature and presents how the thesis makes important contributions to theory, practice, policy and future research. The Discussion chapter also considers the strengths and limitations of the thesis.

Chapter 2: The evidence base for interventions targeted at children and young people who have experienced DVA: A critical literature review

2.1 Introduction

This chapter critically reviews what is known about the evidence base for ‘late’ interventions, whereby interventions are targeted at children and young people who have experienced DVA. In light of the focus of the thesis, the review will examine the literature that discusses intervention effectiveness with regard to intervention outcomes and the reported experiences of receiving or delivering these interventions. This chapter begins by discussing the service delivery landscape in the UK for children and young people who have experienced DVA, and then critically reviews the literature that has explored the effectiveness of interventions delivered in the UK. The chapter closes by drawing out the areas of research that require further exploration in order to develop the evidence base for these interventions, thus, situating the specific focus of the thesis.

2.2 Service delivery in the UK

Government policy in England and the devolved nations recognises the range of ways in which children and young people can be impacted by experiencing DVA, emphasising the importance of establishing available support services for those who have experienced DVA, as well as those who are at risk of doing so (Stanley et al., 2010). National policy in the UK has largely focused on the response by health and social care sectors in providing this support (Cosla, 2008; Home Office, 2009). Whilst English policy particularly focuses on prevention and early intervention approaches, other nations explicitly recognise the need for targeted services for children once they have already experienced DVA (Stanley et al., 2010).

Although the specialist provision of services for children who experience DVA is viewed as paramount, the actual provision of these services in the UK has been described as ‘patchy’ (Howarth et al., 2016). One mapping study examined the available support services for children and families affected by DVA, by conducting a telephone questionnaire with 326 specialist DVA service providers (Humphreys et al., 2000). The findings indicated that the most frequent forms of support available were group-based support, one-to-one support, and advocacy for pre-school-aged children and school-aged children. In 69% of services in England and 89% of services in Wales, Scotland and Northern Ireland, specialist children’s workers were employed but the provision of the services was perceived as comprised due to a lack of funding. Furthermore, 12% of

refuge groups in England and 14% of refuge groups in the rest of the UK reported that they were unable to provide any children's services, again due to limited financial provision. These services were usually dependent on volunteers for sustaining the provision of these services. In relation to services provided locally in England and Wales, 20% of social service departments reported that in their local area, there was no provision for work with children, women or men in situations of DVA, and specific service provision for children living in situations of DVA featured in only 20% of children's services plans.

A second mapping study was undertaken a decade later which examined services available in London (Radford et al., 2011). These findings indicated that 56% of specialist services were provided by the voluntary sector, and there were significant gaps in service provision for children specifically in relation to group work and school-based prevention work. It was observed that the gaps in service provision were due to a lack of sustainable funding, with innovative services only being delivered for a pilot period. This study also observed a lack of 'middle-range' services which were located in between universal services and acute specialist mental health services provided by CAMHS. Moreover, as a lack of frontline services, such as the police, had been unaware of support services available in the community, there were limited proactive responses to DVA. Whilst this mapping study recognised the limited service provision for children and young people, it should be noted that there was a low response rate to the survey (19%) and therefore the findings need to be considered in light of this.

In England and Wales, CAMHS have a remit to deliver services to children experiencing high levels of distress and mental health disorders (Howarth et al., 2016). Although experiencing DVA is recognised as the most frequent type of trauma experienced by children and young people (Meltzer et al., 2009), a CAMHS mapping exercise undertaken in 2008-9 identified that only seven percent of participating services described themselves as providing targeted services for children experiencing DVA (Barnes, Devanney, Uglebjerg, Wistow, & Hartley, 2010). As Stanley (2011) highlighted, there has been a lack of published material that specifies what these specialist services are, thus providing limited insight into what services are available for this population of children.

2.3 Examining the effectiveness of interventions

Whilst it has been argued that the most direct way of preventing the negative implications of DVA for children and young people would be to prevent or end DVA in

itself (Wathen & MacMillan, 2013), the most common approach to preventing or reducing the harm associated with DVA is providing services directly to children and their parents after DVA has taken place (Rizo, Macy, Ermentrout, & Johns, 2011). ‘Late’ interventions for children who have experienced DVA can be categorised as ‘selective’, ‘indicated prevention’ or as ‘treatment’ (Institute of Medicine, 1994). ‘Selective’ interventions are offered to all children who experience DVA or to parents of these children based on the increased risk of maladjustment, irrespective of children’s clinical profiles. ‘Indicated prevention’ interventions are targeted at children showing signs or symptoms of mental, emotional or behavioural disorders but do not meet diagnostic criteria for these disorders, whilst ‘treatment’ interventions are specifically delivered to children who meet certain diagnostic criteria.

In comparison to the substantial body of literature which discusses adverse outcomes associated with children and young people experiencing DVA, there is relatively little literature that considers the most effective responses. Reasons for this have been attributed to the population being ‘hard to reach’, as well as the varied nature of service provision between localities (Bunston, Pavlidis, & Cartwright, 2015; Stanley, 2011). Whilst a range of interventions or programmes may exist for children, very few have been evaluated, as they are often delivered by underfunded, community-run organisations which have limited available resources for conducting service evaluations (Bunston et al., 2015; Campo et al., 2014; Kwok, 2013).

To date, there have been few reviews of the evidence which have explored the effectiveness of interventions targeted at children and young people who have experienced DVA (British Columbia Centre of Excellence for Women’s Health-BCCEWH, 2013; Graham-Bermann, 2000, 2001; Graham-Bermann & Hughes, 2003; Howarth et al., 2016; Rizo et al., 2011; Stanley, 2011). Collectively, the existing reviews pool together international studies that have evaluated these interventions. Reviews undertaken by Graham-Bermann (2000; 2001) and Graham-Bermann & Hughes (2003) were the first to amalgamate the literature on interventions for children who have experienced DVA, given that the first intervention programmes for this population were not developed until the 1980s. It was only in the mid to late 1990s that the evaluations of these interventions became more rigorous and systematic, as informal evaluations had previously assessed the early designed interventions which were often neither standardised nor manualised (Graham-Bermann, 2000). This section now critically reviews the three most recent evidence reviews to date regarding the effectiveness of interventions targeted and children and young people who have experienced DVA.

2.3.1 The effectiveness of interventions- Rizo et al. (2011)

Rizo et al. (2011) conducted the first known systematic review which aimed to evaluate what was known about services for children who had experienced DVA, either through providing direct services for children, or through indirect services for mothers and/or fathers, such as parenting or counselling classes, which were expected to have a positive impact on children's health and well-being. The systematic review comprised reviewing the international literature of empirical studies published between 1990 and 2010, whereby data had been collected and analysed in relation to interventions or services which had focused on helping children who had experienced DVA and measured child outcomes. Case studies and qualitative papers were excluded and articles had to be available in English. Out of 31 studies that were identified as being eligible (one of which was a UK based study), Rizo et al. (2011) developed four categories of interventions:

- i) *Counselling and therapy* (12 studies; six interventions delivered to children and six interventions delivered to both children and caregivers). These sought to improve child functioning by developing coping, safety, communication, conflict resolution, and problem-solving skills, as well as increasing children's understanding of DVA.
- ii) *Crisis and outreach* (Four studies; two interventions were for mothers only and two delivered services to children and caregivers). The crisis and outreach interventions for mothers aimed to improve children's externalising and internalising behaviours, by increasing mothers' knowledge about safety planning and community resources. The interventions for children and caregivers aimed to link families to community resources and improve safety, coping skills and emotional health and improve child behaviour.
- iii) *Parenting* (Three studies; one intervention focused on mothers; one intervention focused only on fathers; and one focused on both children and caregivers). Parenting interventions shared the general goal of improving parenting, which involved reducing parenting stress and improving the parent-child relationship.
- iv) *Multi-component* (12 studies). The broad multi-component category included interventions provided to children and their caregivers, most of which provided some combination of parenting, therapy and advocacy. The most common multi-component intervention provided parenting and therapy support (nine studies).

There were a number of methodological limitations of the studies reviewed by Rizo et al. (2011), such as small sample sizes (often less than 40 participants), missing data, and a lack of longitudinal follow-up of outcomes post-intervention. The voice of the child was often missing from the studies with only 14 studies collecting data directly from the children themselves, as data was usually provided by mothers. In light of these limitations, conclusions could not be made about the effectiveness of the interventions and what type of intervention warranted research priority. It was recommended that future studies should seek to recruit larger samples, account for missing data, follow up participants beyond the end of the intervention and use randomised experimental designs.

2.3.2 The effectiveness of interventions- BCCEWH (2013)

Building upon Rizo et al.'s (2011) review, BCCEWH (2013) were commissioned to inform the National Institute of Clinical Excellence (NICE) 2014 guidelines on DVA, by reviewing evidence for interventions that were "*effective in identifying and responding to children who were exposed to domestic violence*" (Howarth et al., 2016, p.13). In this review, Rizo et al.'s (2011) systematic review was identified as the only previous systematic review that had explored the effectiveness of such interventions. However, BCCEWH (2013) adopted different search methods and exclusion criteria. The search criteria included studies that had been conducted between 2000 and 2012 and a wider range of study designs, including RCTs, cross-sectional studies, cohort studies, observational studies, qualitative evaluation studies and studies included in grey literature. Similar to Rizo et al.'s (2011) review, it was ensured that outcomes for children had been measured and reported in the studies. In addition to the 25 studies of the identified by Rizo et al. (2011), BCCEWH (2013) identified 13 additional studies (two studies were conducted in Australia; two in the UK; one in Sweden; and eight studies were conducted in the USA). In total, 38 studies were included in the review, and were categorised into different intervention types.

The categories were based on the following three main characteristics of an intervention: i) single or multiple components; (ii) interventions delivered to the child only or to the mother and child; and (iii) intervention content, such as therapy, advocacy or parenting. The seven categories identified were as follows:

- i) *Single component therapeutic interventions delivered to mother and child* (six studies)
- ii) *Single component psycho-education interventions delivered to mother and child* (four studies)

- iii) *Single component therapeutic interventions delivered to child only* (three studies)
- iv) *Single component psycho-education interventions delivered to child-only* (six studies)
- v) *Multi-component interventions focused on advocacy* (five studies)
- vi) *Multi-component interventions focused on advocacy and therapy* (four studies)
- vii) *Multi-component interventions focused on therapy and parenting* (10 studies)

With regard to the effectiveness of the seven categories of interventions identified by BCCEWH (2013) it was concluded that there was, ‘moderate to strong evidence’ that psychotherapeutic interventions delivered to children and mothers improved child outcomes; ‘moderate evidence’ for psychoeducational interventions delivered to children; ‘moderate evidence’ for parenting-focused interventions, and ‘mixed evidence’ for psycho-educational interventions delivered to mothers and children improving outcomes. In the case of single focus interventions, interventions aimed at mothers and children together appeared to be more beneficial in improving child behaviour, mother-child attachment and stress and trauma-related symptoms in mothers and children. As reported outcomes differed across the studies, it was not specified how the ‘strength’ of the evidence could be concluded and compared between intervention types.

In addition to the varied nature of the outcomes measured across studies, the conclusions that could be made were largely based on non-experimental research and only three studies had been conducted in the UK (one in the grey literature and two were peer-reviewed studies), which limited the extent to which the results could be translated to the UK context. Similar to Rizo et al.’s (2011) observations, it was reported that the majority of studies that compared pre- and post-intervention outcomes did not have follow-up points. There were also difficulties in comparing the benefits of different modalities of intervention components due to a lack of reporting effects in the studies. Similar to Rizo’s et al.’s (2011) review, less than half of the studies had directly collected data from children, and again adult-informed reports of children’s outcomes were dominant. However, the findings from this review informed the NICE (2014) guidance on DVA, which recommended that specialist services for children and young people should include interventions that aim to strengthen the relationship between the child or young person and their non-abusive parent or carer, which may involve individual or group sessions, or a combination of the two, and should also focus on the impact of DVA on parenting.

2.3.3 The effectiveness of interventions- Howarth et al. (2016)

Building upon the findings from Rizo et al. (2011) and BCCEWH (2013), the most recent evidence review to date was conducted by Howarth et al. (2016). An evidence synthesis was implemented to assess the clinical effectiveness, cost-effectiveness and acceptability of interventions for children who had experienced DVA. This more recent review of the evidence comprised: a systematic review of controlled trials of interventions; a systematic review of qualitative studies of participant and professional experiences of interventions; a network meta-analysis (NMA) of controlled trials; a cost-effectiveness analysis; an overview of current provision of interventions in the UK; and consultations with young people, parents, service providers and commissioners about interventions for children who have experienced DVA. Whilst discussions relating to the findings of the cost-effectiveness of interventions and NMA are beyond the scope of this review, this chapter now critically reviews the findings from the systematic review of controlled trials of interventions and the qualitative studies, and the consultations with key stakeholders.

Howarth et al. (2016) undertook a narrative synthesis of the evidence to allow for the juxtaposition of the findings from the different evidence sources within each of their research questions (Dixon-Woods et al., 2005). Whilst this informal approach has been critiqued with regards to subjectivity and a lack of transparency (Pope, Mays, & Popay, 2006), this synthesis only included ‘well-defined’ interventions, and it was acknowledged that much of the support offered to children through specialist DVA services was informal, unstructured support, and was likely to reach those families who may not have the opportunity to engage with a specific intervention. Furthermore, the focus of this synthesis was on interventions targeted specifically at children who experienced DVA, thus not reflecting the impact of interventions that would be delivered to other populations that would include children who have experienced DVA. As DVA can occur in a constellation of risk, children and adults experiencing DVA may seek support from other types of services that may directly or indirectly address the impact of DVA (Stanley, 2011). As evaluations of such services did not report outcomes for DVA separately, these studies were excluded from Howarth et al.’s (2016) synthesis.

With regard to Howarth et al.’s (2016) systematic review for controlled trials, studies were included if interventions were delivered to children or parents only, or to both children and parents, and specifically reported child outcomes. Reported child outcomes included children’s behaviour, mental health, school attainment, school

attendance, self-esteem, self-competence or self-efficacy, children's happiness, children's quality of life and if there had been intervention of social services. Studies were excluded if they did not have a control group which was either concurrent or temporal. Whilst the initial search for controlled trials included studies conducted from inception to April 2013, searches were also conducted in September 2015. Thirty-four relevant papers published between 1995 and 2015 were identified, in relation to 13 primary research studies (1345 participants in total), regarding ten separate interventions. It should be noted that nine studies were RCTs and four were controlled clinical trials. Furthermore, none of these studies were based in the UK.

Similar to the reviews conducted by Rizo et al. (2011) and BCCEWH (2013), Howarth et al. (2016) categorised the interventions. However the categorisation was founded on the main therapeutic emphasis of the interventions (based on seven components- advocacy; emotional support; group activities; parenting skills training; play therapy; psychoeducation and psychotherapy; and various control conditions). Five distinct intervention categories of interventions emerged, which were as follows:

- i) Psychotherapeutic, including play therapy; (five studies)*
- ii) Psychoeducational; (four studies)*
- iii) Parenting skills training plus advocacy; (two studies)*
- (iv) Psychoeducation plus advocacy; (one study)*
- (v) Advocacy (one study)*

Whilst Howarth et al. (2016) used the main therapeutic aspects of the intervention as the basis for categorisation, it should be noted that they did not include the mode of delivery (group or individual), or the intervention target (mother, child or mother and child) in this classification, based on the premise that too many classifications would have been created from which to divide the relatively few studies. Howarth et al. (2016) explicitly provided a detailed definition and description for each intervention type (see Table 1 in Howarth et al., 2016).

The trials most frequently evaluated psychotherapeutic and psychoeducational interventions delivered to the non-abusive parent (mostly mothers) and children, although the format in which an intervention was delivered (in groups, individual, dyads, or a combination) varied between programmes. In the UK, the most common intervention model delivered was group-based psychoeducation, either delivered to both parents and children in parallel, or to children or young people alone.

Similar to the conclusions made by Rizo et al. (2011) and BCCEWH (2013), it was inconclusive as to which interventions were effective. As none of the studies were

based in the UK, there were also limitations regarding the extent to which the results translated to the UK context. However, based on the results from the synthesis of trials it was suggested that group-based psychoeducation, and parent-skills training, in combination with advocacy were likely to be the most effective interventions and would benefit from further research. It should be noted that comparator interventions had been used in order to enable the comparison of outcomes and to isolate the impact of the targeted intervention. Whilst five studies used a comparison that was either a waitlist control or delayed control, treatment as usual or no intervention, four studies used a minimum active intervention, such as allowing mothers to access a play room with their children. One of these studies provided a group activity of similar duration and intensity as the intervention, but without the focus on DVA, and four studies used an active control of psychotherapy, psychoeducation or advocacy.

What was identified by Howarth et al. (2016) as problematic in synthesising the evidence across the trials, was outcome heterogeneity and inconsistencies in the tools used to measure outcomes. Authors of a number of DVA intervention reviews have also identified the problem of heterogeneity in outcome measurement in relation to victim/survivor interventions, calling for efforts to seek consensus on what outcomes should be measured in DVA trials, and what tools should be used to measure them (Feder et al., 2009; Jahanfar, Janssen, Howard, & Dowswell, 2013; O'Doherty et al., 2014; Ramsay et al., 2015). Findings from the wider study conducted by Howarth et al. (2016) proposed that these outcomes were a “*narrow set of health outcomes*” and only partially represented what constituted as success to stakeholders (Howarth et al., 2016, p.161). In comparison to the area of mental health which has paid more attention to outcomes that are meaningful to stakeholders, there has been no consensus about what specific outcomes to measure in relation to children who have experienced DVA (Howarth et al., 2015).

Howarth et al.'s (2016) qualitative synthesis aimed to identify what factors contributed to the effectiveness of an intervention, by examining the benefits or harms of interventions that would not necessarily be captured by the limited range of outcomes measured across trials (Rees et al., 2006). The qualitative synthesis of international empirical studies that used qualitative methods for data collection and analysis was conducted. Studies that were included in the synthesis focused on the views of children, parents or service providers and their experiences of receiving or delivering child-focused interventions following children's experiences of DVA. Studies that were eligible for inclusion were either discrete components of a mixed-method study or a

standalone study. Howarth et al. (2016) also specified that the studies needed to have undergone some level of peer review as a published article or report and subsequently the studies identified were assessed using the Critical Appraisal Skills Programme (CASP, 2010) tool. Nine papers (two of which were based in the UK) were identified and had been published between 1992-2012, reported on five separate interventions in total and were conducted either in the UK or USA. The quality of all the studies according to the CASP tool was relatively high, with only three studies scoring below the maximum score of 10 points, but not below six points which was viewed as demonstrating good or acceptable methodological quality and therefore were included in the synthesis. Out of the nine papers, four reported children's views, six reported parents' views and six reported stakeholders' or practitioners' views. Three of the five interventions identified from the qualitative synthesis were described as psychoeducational interventions. The fourth intervention was a self-help intervention used in a refuge setting, whilst the fifth type combined play therapy and psychoeducation in a school setting. The studies identified were conducted in the UK and USA. Howarth et al.'s (2016) synthesis adopted a systematic interpretive approach to reinterpret the findings from these studies in order to develop overarching constructs. This involved identifying the accounts of children, parents and professionals and identifying the implications of the data and interpretations of the authors in relation to participants' experiences of interventions.

The qualitative synthesis highlighted the importance of children and parents being ready to attend an intervention and this was a continual process throughout an intervention, which had implications on intervention engagement. It was recommended that defining and assessing readiness needed consideration by those involved in designing and delivering interventions. It was proposed that readiness could be facilitated in practical ways through priming or pre-intervention support, which could involve communicating information about the intervention content or reassuring individuals about concerns of confidentiality.

The way in which interventions were delivered appeared to have implications on how the interventions were experienced, whereby group-based interventions were associated with benefits for children and mothers such as making friendships and having fun. Interventions that involved both children and mothers provided the additional benefits of them spending time together and improving the mother-child relationship. This supported findings from the BCCEWH (2013) review and a previous non-

systematic evidence review (Stanley, 2011) which identified the importance of parental engagement.

Overall, the qualitative studies highlighted the invaluable contribution of qualitative research in capturing the fuller potential impact of interventions and the importance of considering measuring outcomes identified by those receiving and delivering interventions, as well as identifying the challenges associated with participating in DVA interventions. The reported benefits of participating in an intervention were much broader than the limited health-focused outcomes measured in the trials. Thus, the qualitative studies identified that the wider context in which interventions were delivered could impact the delivery and outcomes of an intervention, such as the readiness of organisations in training intervention facilitators.

2.4 Intervention effectiveness in the UK context

It is important to consider what can be concluded about intervention effectiveness within the UK context. In light of this, there are important findings to consider in light of two UK- based studies which formed part of Howarth et al.'s (2016) evidence synthesis, the only known study to date which has synthesised the evidence on the effectiveness of interventions specifically delivered in the UK. Before discussing the specific findings that arose from these studies, both studies will be discussed in light of their design, methods and limitations.

2.4.1 A review of UK intervention studies

The first of the two UK based studies conducted by Howarth et al. (2016) was a review of UK intervention studies. This review included documents that were official publications from government departments, charities and official bodies, dissertations and theses, or a conference paper, which were all available in English. To be included in the review the interventions had to have been delivered in the UK during 2004 or later in order to reflect more recent or current UK practice, and were targeted at children and young people or their parents who had experienced DVA. It was also expected that each intervention aimed (or in part) to improve children's health outcomes. The identified papers described 19 interventions, 16 of which targeted children who had experienced DVA, and three which specifically targeted children with behavioural problems and who had experienced DVA. Eight interventions were delivered to children, eight to children and their mothers, two interventions were delivered to the whole family (perpetrator, victim/survivor and children), one was delivered to the mother only, and one was delivered to the perpetrator only although information and risk monitoring was provided

to children and mothers. The 19 interventions were categorised using the taxonomy of intervention types Howarth et al. (2016) developed in the intervention trial and qualitative syntheses. The most frequent type of intervention delivered in the UK was psychoeducational (nine interventions) and it was commonplace for DVA interventions to be offered to children in light of their experience of DVA rather than specific social or clinical needs.

Out of the 19 interventions, 17 had undergone some level of evaluation which were reported in 21 studies overall; only one evaluation included a comparison group, whilst the remaining were based on one intervention cohort which either compared pre and post intervention outcomes, or data was collected after participating in the intervention. Out of 21 studies, 11 used a mixed-methods design, drawing on a combination of evaluation approaches including, qualitative methods (interview, focus group, case study, and observation), questionnaire surveys, economic analysis, and an analysis of routinely collected data. Across the studies 11 separate studies reported child behaviour outcomes, as measured through either the child or parent perception and/or by standardised measures, whereby there was a greater focus on child behavioural outcomes as opposed to mental health outcomes such as depression and anxiety. Child-focused measures that were used to measure outcomes included the Goodman's Strengths and Difficulties Questionnaire (1997), the Adolescent Wellbeing Scale (Department of Health, 2000), the Kidscreen-52 quality of life measure, (Ravens-Sieberer et al., 2005) and the Child Behaviour Checklist (Achenbach, 1991).

With regard to the sample sizes of the studies, eight studies included samples of ten or fewer children, and five reported samples between 26 and 50 children. It should be noted that none of the studies 'followed-up' the children after they had completed the intervention. Intervention outcomes or experiences were informed directly by a combination of asking both child and parent or asking either the child or parent.

2.4.2 Consultations with UK stakeholders

The second UK based study conducted by Howarth et al. (2016) specifically comprised consultations that had been conducted with stakeholders between 2013 and 2014. The stakeholders included six young people (aged between 12 and 21 years) who had experienced DVA, four mothers who had experienced DVA and had received a DVA intervention, and 20 professionals which included practitioners, commissioners, policy-makers and researchers. Stakeholder views were sought in relation to: the current service delivery context in the UK; gaps in service provision; the acceptability of available intervention types, service settings and the characteristics of those delivering

services; outcomes prioritised by stakeholders; and priorities for future research. As only young people who were at least 12 years of age were consulted, the voices of younger children were missing from the consultation. Furthermore, all of the young people involved in the consultations had received support from a specialist DVA agency. Thus, their views may not have reflected those of other young people who had accessed different types of services, or no services at all. In relation to the professionals, there was a stronger representation from non-statutory organisations compared to statutory sectors such as CAMHS, criminal justice and health. The overall findings from these two UK focused studies, explored as part of Howarth et al.'s (2016) wider research study, will now be discussed in order to consider what is known about interventions delivered specifically in the UK context.

2.4.3 The acceptability of interventions

The findings from both studies identified that a broader range of professionals from voluntary and statutory sectors were involved in delivering UK interventions compared to those reported in the peer-reviewed international literature, which Howarth et al. (2016) attributed to the strong multi-agency working ethos in the UK. The findings from the qualitative studies and consultations with stakeholders recognised that symptom reduction was deemed to be important. However, functional outcomes such as improvement to relationships, wellbeing, self-esteem, and school attainment were also important to consider in light of evidencing intervention effectiveness. Furthermore, the perceived benefits of psychoeducational interventions (the most common type of intervention delivered), were reported by children as, having fun, making friends and realising that they were not alone in their experiences, all of which derived from the group process of an intervention. It was also identified that unintended outcomes of interventions which may lead to negative consequences (such as discomfort in managing negative emotions) should be measured in trial-based studies.

The extent to which interventions were acceptable with regard to their uptake and completion could not be explored in depth from the trial studies. However, the qualitative findings and stakeholder consultations observed large differences between the number of children who were referred to an intervention and the number who attended. This suggested that inappropriate referrals may have been made, as well as a possible lack of engagement from children and parents. Although completion rates in UK reported studies were generally observed to be high (75-85%), practical issues as well as diffidence were reported as presenting barriers to mothers' attendance, which could in turn influence their child's attendance.

It was observed that emphasising confidentiality in the children's groups made it difficult for children to decide what was permissible to share with friends and family, and there was a sense of parental frustration and exclusion at not knowing what was being discussed within the groups. Parents also felt challenged by questions asked by their child following intervention group discussions, which parents found upsetting and difficult to deal with, even if they were supportive of a child's involvement in an intervention. Parental engagement in parallel group sessions was identified as important in mitigating feelings of exclusion or feeling challenged as parents had a greater understanding of the content delivered to their child. It was identified that parents who were not fully engaged in their child's therapeutic journey may lead to alienating parents from supportive services entirely. There were concerns raised by mothers and professionals regarding the appropriateness of interventions that included the perpetrator, especially when relationships continued to be dominated by coercive control.

2.4.4 Supporting ongoing DVA

One of the salient themes to emerge from consultations with expert stakeholders was the need to establish evidence that interventions were safe, appropriate and effective for children who lived with ongoing DVA, particularly if children continued to live with a perpetrator of DVA. This has been previously highlighted as a problem of concern in the UK, as children may more assertively challenge the behaviour of parents after attending an intervention that has helped to 'reframe' their experiences, potentially increasing their risk of harm (Radford et al., 2011). In the UK interventions reviewed by Howarth et al. (2016), most studies reported that the interventions did not specifically exclude those children who lived with a perpetrator of DVA. Whilst it has not been explored as to whether experiencing subsequent DVA during the course of an intervention can moderate treatment outcomes, consultations with young people and mothers highlighted the importance of establishing some form of available intervention when DVA continues.

2.4.5 Intervention 'readiness'

Intervention readiness was identified as a prerequisite for children and parents engaging with an intervention. Intervention readiness refers to "*a person's willingness to change their behaviour and/or engage in an intervention*" (Howarth et al., 2018, p.3). Howarth et al. (2016) reported that if children were at an earlier stage of recovery, it was identified that they may benefit from an intervention in relation to their willingness to discuss DVA, rather than benefitting from a reduction in symptoms. For mothers,

readiness involved acknowledging that their child had been impacted by DVA, being able to focus on her child beyond her own practical and psychological needs, and no longer being situated in the initial crisis that led her to seek support. Professionals suggested the role of pre-intervention work for engaging those who were ‘not ready’, in order to facilitate readiness.

2.4.6 Age appropriateness

Most studies sampled children aged between four and 14 years, and there has largely been little focus on the age appropriateness and potential impact of interventions for children of different age groups. However, as an exception, Graham-Bermann, Howell, Lilly, & DeVoe (2011) found no significant effects of age in predicting changes in internalising and externalising behaviour problems. In Howarth et al.’s (2016) consultations with professional stakeholders, they emphasised the importance of tailoring interventions according to a child’s developmental stage. Young people also highlighted that age was an important factor when considering the acceptability of interventions that required the involvement of parents. Help seeking in the form of parent-child dyads after 12 years was viewed as inappropriate, although parental support of intervention attendance was still valued.

2.4.7 Cultural appropriateness

With regard to the cultural appropriateness of interventions, young people and professionals emphasised the importance of establishing culturally appropriate interventions. The observations made in one UK evaluation of the guided self-help intervention conducted by Humphreys et al. (2006a) highlighted that stakeholders who worked with women from minority ethnic groups identified concerns regarding confidentiality, and parents’ limited parenting role, which could impact intervention outcomes especially when the intervention focused on improving the quality of the mother-child relationship. Furthermore, the concept of cultural-priming was viewed as important, before embarking on an intervention that focused on improving the quality of the parent-child relationship.

2.4.8 Intervention- related factors

In relation to the length of the interventions, professionals identified that a child’s attendance at an intervention reflected “*one step in a long journey*” (Howarth et al., 2016, p.67). Young people felt that an intervention should be longer than three months but shorter than one year, on the basis that it took time to build trust with others in the intervention group.

Having intervention facilitators who could engage with children and parents was also deemed to be paramount. Facilitators' personal attributes helped to build this alliance particularly with parents, whereby this was easier with a facilitator who parents perceived as being similar to them in relation to background and age. Whilst young people acknowledged that a facilitator should be knowledgeable about DVA, their qualifications held less priority to that of their interpersonal skills. In the context of the intervention trials, Howarth et al. (2016) identified that those who delivered the interventions were usually graduates with expertise in mental health related disciplines. However, in Howarth et al.'s (2016) study which reviewed interventions in the UK specifically, the interventions were usually delivered by specialist DVA workers or groups of professionals with more diverse backgrounds.

There was broad congruence between the settings in which interventions were trialled and those in which UK programmes tend to be delivered. In contrast to mothers and professionals who identified primary health care settings as a possible intervention setting, young people felt that such settings were too 'clinical' in comparison to DVA agency settings. These were perceived as being more relaxed and provided a space for young people to socialise before and after an intervention group. Furthermore, the geographical setting in which an intervention was delivered (rural or urban) was identified as having implications for intervention delivery and engagement. For example, delivering an intervention in a location that covered a large geographical area, which has limited transport facilities, created barriers to intervention uptake. As a result, this impacted the likelihood of when group interventions were delivered, especially if the delivery of an intervention depended on filling a certain number of places in a group.

2.4.9 Organisational and community context

A particular concern regarding the wider context in which interventions were delivered related to the funding cuts experienced by specialist DVA services, whereby funding was often piecemeal and short-term. This limited the range and amount of services that were available. It was anticipated amongst practitioners that this would lead to services wanting to offer 'something rather than nothing', and the changing nature of the delivery landscape could also lead to ambiguity about what services were available. The organisational context in which services were delivered was also identified as either facilitating or hindering the delivery of interventions. Well-resourced organisations with strong leadership could better ensure the implementation of an intervention, compared to organisations which were characterised by staff shortages, inadequate funding and chaotic working practices (Humphreys, Thiara, & Skamballis, 2011).

Contextual factors such as whether an intervention was embedded in a broader co-ordinated community response to DVA and multiagency ‘buy in’, were seen to influence the perceived credibility and sustainability of a specific intervention. In light of the range of service and community contexts in which interventions could be delivered, professionals questioned whether standardised intervention models could be adapted whilst preserving the integrity and effectiveness of an intervention. Although local-level adaptation was viewed as important for maximising effects and encouraging ongoing sustainability (Bisset, Potvin, & Daniel, 2013), there is debate concerning the extent to which complex interventions can be adapted to suit different contexts, whilst not compromising their integrity (Moore et al., 2015).

2.4.10 Tools used to measure intervention effectiveness

In consultations with intervention providers, it was reported that they lacked appropriate tools to routinely monitor and report outcomes to funders. This had implications for securing funding in a competitive environment. Having a routine outcome tool that could be used across different types of programmes and service providers was identified as being able to potentially help services in delivering evidence-based interventions and to demonstrate their impact. Collecting routine data as part of assessing children’s risk and need was viewed as an opportunity to establish a baseline against which to measure a change in children’s symptoms and well-being at the end of an intervention. Using available routine information has been shown to improve treatment outcomes in adult-focused clinical settings (Reese, Norsworthy, & Rowlands, 2009) and is increasingly being integrated into the practices of child and adolescent services (Hall et al., 2013; Timimi, Tetley, Burgoine, & Walker, 2013)

2.5 Gaps in research

In light of the literature reviewed in this chapter, this section highlights a number of key research gaps in the context of the evidence base of interventions for children who have experienced DVA. Addressing these research gaps may help to identify and respond to the structural, practical and cultural barriers that have hampered the development of the UK evidence base to date, and doing so by reviewing existing interventions that are delivered. However, one main challenge of this is the absence of a national repository of interventions delivered in the UK for children who have experienced DVA (Howarth et al., 2016).

2.5.1 The voice of the child

The findings from Howarth et al.'s (2016) qualitative synthesis and consultations with intervention stakeholders have emphasised the importance of qualitative studies in preserving the perspectives of stakeholders, which can inform the future development of UK trial-based studies. Thus, the role of qualitative studies is important at this point in time, given that the effectiveness of interventions for children who have experienced DVA remains inconclusive. Specifically, there has been limited research exploring the direct experiences of children who have participated in a DVA intervention (particularly younger children below 12 years), and perceptions about the acceptability of interventions in light of ethnic groups, age groups, experiences of other types of trauma and children's clinical profile (Howarth et al., 2016). The role of qualitative studies may serve the purpose of contributing to identifying meaningful outcomes whilst preserving the perspective of a range of stakeholders (Williamson et al., 2017), and importantly including the voices of children and young people. Whilst researchers have begun to involve young people who have experienced DVA as research advisors and even as active participants in the development and piloting of interventions (Barter et al., 2015; Houghton, 2015; 2017; Callaghan & Alexander, 2015; Humphreys, 2006), the voice of the child still requires prioritisation in relation to informing interventions for children and young people.

2.5.2 Lack of consensus about outcomes

There has been limited investigation about what constitutes success for interventions targeted at children who have experienced DVA. The lack of consensus about what outcomes to measure and how, has meant that limited comparisons can be made when comparing outcomes across trials. Moreover, the synthesis of evidence is challenging due to the generation of incomparable scores that derive from different instruments measuring outcomes that range in their reliability and validity (Tunis et al., 2016). In turn, this has contributed to an underdeveloped evidence base of interventions that target this population of children (Howarth et al., 2016).

Whilst a recent consensus about what outcomes should be measured for assessing the effectiveness of DVA perpetrator programmes has been established (Kelly & Westmarland, 2015; Westmarland & Kelly, 2012) there have been attempts to explore outcomes for children within the context of DVA perpetrator programmes (Alderson, Westmarland, & Kelly, 2013). In this context, children's improved safety and wellbeing, along with improved father-child relations, children's ability to express feelings, enhanced school performance and positive peer relationships have been identified as

markers of an intervention's success (Kelly & Westmarland, 2015). Importantly, the views of children were directly consulted in identifying these outcomes (Alderson, Kelly & Westmarland, 2015). This raises important questions about recognising the value of the voice of the child in contributing to intervention evaluation and developing the evidence base in relation to interventions specifically targeted for children. It also raises questions about the additional implications of having no consensus about outcomes for this group of children, in light of other types of DVA interventions, such as interventions for DVA perpetrators. Illustrating this, the conclusions from a recent evaluation of the Caring Dads Safer Children (CDSC) perpetrator programme argued that although outcomes for children were measured in their study, the findings were limited, because no general consensus of outcomes for children who have experienced DVA has been clearly established. As a result, this limited the extent to which outcomes for children could be compared and synthesised across studies that explore the effectiveness of DVA perpetrator programmes, such as the CDSC programme (McConnell, Taylor, & Barnard, 2017).

Measuring outcomes not only enables the comparison of the benefits and harms of treatment between trials, but it is also paramount for clients and practitioners to be best informed about the intervention choices they make (Davis, et al., 2018; Sox & Greenfield, 2009). The heterogeneity of outcome reporting in trials has also been evident even when exploring the effects of the same intervention on a specific condition or disease (Williamson et al., 2012), which has led to limitations in comparing outcomes and wasting research resources (Chalmers & Glasziou, 2009; Macleod et al., 2014). However, the systematic development of core outcome sets (COS) which represents an agreed minimum set of measured outcomes in all trials relating to a specific health condition or clinical area, may contribute to reducing inconsistency and selective outcome reporting, thus preventing a waste of research resources (Williamson et al., 2017). Developing COS would not restrict researchers from measuring additional outcomes, which has been explored in clinical trials for rheumatoid arthritis (Kirkham, Boers, Tugwell, Clarke, & Williamson, 2012). However, the scope of implementing COS for any population requires discussion as to whether the COS is applicable to all interventions or only to specific intervention types (Davis et al., 2018). The absence of COS for children who have experienced DVA, as well as the few attempts to consult children directly about this, may not only be attributable to the more recent development of interventions for this population in comparison to other domains, but as reviewed in

Chapter 1, it may also be due to children being positioned as silent within the wider DVA literature.

2.5.3 Identifying additional factors hampering the evidence base

In light of having no consensus of outcomes for this group of children and young people, it is perhaps unsurprising that there has been a lack of research examining additional factors impacting the evidence base of interventions for this group of children and young people. These include the range of factors that can mediate outcomes and impact experiences of those receiving and delivering interventions, thus influencing the effectiveness of interventions. There has been limited exploration of the context in which interventions are delivered, such as examining the qualities and qualifications of individuals who deliver interventions, and the organisational and community context in which interventions are delivered (Howarth et al., 2016). Examining factors such as these may enable the identification of practical, structural or cultural factors that may present difficulties in demonstrating the effectiveness of interventions for children who have experienced DVA.

2.6 Research questions

In light of the aforementioned gaps in research, the following research questions of the thesis were developed:

- 1) How do intervention recipients and providers perceive interventions targeted at children and young people who have experienced DVA?
- 2) How can the evidence base be improved for interventions targeted at children and young people who have experienced DVA?

2.7 Chapter summary

The available evidence about the effectiveness of interventions delivered in the UK for children who have experienced DVA is currently inconclusive. This is largely due to limitations associated with study designs and a lack of consensus about what outcomes to measure and how. As a result, it cannot be concluded as to which interventions are effective for children who have experienced DVA, even when considering short-term effectiveness. This is particularly concerning as the provision of these services is usually reliant on evidencing intervention effectiveness. There are few qualitative studies that have explored the experiences of providers and recipients in

relation to these interventions, but there is a particular role for qualitative studies in developing the evidence base of these interventions. Qualitative studies may play an invaluable role in informing future intervention trials and evaluation studies, as well as informing decision-making processes regarding the commissioning, designing and developing of interventions, in ways that are meaningful to stakeholders. The specified research questions of the thesis aim to contribute to developing and strengthening the underdeveloped evidence base of interventions for children and young people who have experienced DVA.

Chapter 3: Study 1- The initial study

3.1 Introduction

For ease of reading, this is a self-contained chapter that presents Study 1 in light of its aims, methodology and findings. It begins by providing an overview of the context in which the initial focus of the thesis was situated, followed by an account of how the research was conducted, and the findings of the study. The chapter concludes by highlighting what lessons were learned from this study. This chapter is positioned at this particular point in the thesis in order to help the reader understand how the thesis evolved.

3.1.1 The background context of the thesis topic

The PhD research that I had originally pursued for this thesis was located in the arena of child protection in law enforcement, but due to unforeseen circumstances the specific project had to be abandoned. The opportunity of researching within the field of DVA arose through establishing contact with a DVA organisation in 2014. The DVA organisation provided a range of services for perpetrators of DVA, as well as adults and children who had experienced DVA. It was proposed that I examined the effectiveness of the interventions provided by the DVA organisation for children who had experienced DVA. At the time this seemed promising in light of the limited UK research in this area of work, and in keeping with my interest of child protection research. Given the small-scale nature of the study, certain details which may compromise the anonymity of the DVA organisation, children and their families, will be omitted from the thesis. Furthermore, the name of the organisation throughout the thesis will be referred to as '*the DVA organisation*' rather than its known name.

The DVA organisation had been commissioned by a Local Authority to provide a suite of interventions for children and young people. The commissioners had identified two 'resilience building' interventions that were to be provided as part of this funding. These interventions targeted children and young people who had experienced DVA but were also available to those children who had experienced behavioural problems and were at risk of being involved in violent relationships. The resilience building interventions were developed by a clinical specialist and these had been delivered in different localities across the UK in community and educational settings. The commissioners asked the DVA organisation to identify an additional intervention which could be provided, but one that was exclusively for children who had experienced DVA. The DVA organisation identified a 'recovery' intervention that had been delivered in the

same locality by a larger national organisation, but due to funding cuts the provision of the intervention became unsustainable. The adoption of this specific recovery intervention by the DVA organisation was therefore serendipitous.

Being commissioned to provide the three interventions involved the DVA organisation receiving and managing referrals. Children and young people could be referred through a range of referral routes, such as through schools, health practitioners, and referrals made by their parents. The DVA organisation was also responsible for screening children for their eligibility to attend the interventions, allocating children to an intervention cohort, and coordinating when and where the delivery of an intervention took place in the community. The DVA organisation relied on their employees as well as those employed by local agencies to assist in the delivery of the interventions, of which included individuals who had been previously trained in delivering the recovery intervention. There was an expectation that the DVA organisation would provide an account of the effectiveness of the interventions it provided.

The goal of evidencing the effectiveness of the interventions was shared by the rationale underpinning my aim to explore the effectiveness of the three interventions. I pursued this aim based on the understanding that I could analyse pre- and post-intervention outcome and evaluation data that had been collected by the DVA organisation, as well as collecting some additional data myself. However, as it will be discussed, over time it became clear to me that the data could not be used to produce the robust evidence about the effectiveness of the interventions that had been initially envisaged. This alarming realisation produced key lessons for both me and the DVA organisation, and to which I will return later.

3.2 The interventions

The three interventions can be categorised as ‘psycho-therapeutic’ interventions, as defined by Howarth et al. (2016), whereby the interventions provided children and young people with the opportunity to work towards a better understanding of themselves, their relationships and their established patterns of behaviour, based on therapeutic relationships developed through talking or play. The interventions were ‘indicated prevention’ interventions (see Chapter 2), whereby the interventions targeted children and young people who demonstrated signs of mental, emotional or behavioural difficulties, but did not meet diagnostic criteria for these disorders. It should be noted that all three interventions could be delivered in a group setting (ideally a group size was between six to eight children and young people), or on a one-to-one basis if children and

young people had additional needs that were likely to disrupt a group environment. For all three interventions, parents (who were not DVA perpetrators) were invited to attend parent sessions, which were not compulsory but were highly recommended. The parent sessions aimed to help parents (or another appropriate caregiver) understand what the children had been learning about so they could provide further support in the home environment. Children and young people could be removed from the intervention if they missed more than three intervention sessions or were behaviourally disruptive in such a way that it compromised the safety of other children and/or those delivering the intervention. Those individuals delivering the interventions were informed that they could adapt how they delivered the intervention sessions, as long as this did not undermine the aims of each session. The following section outlines further details about the interventions. For the purpose of anonymity, the interventions will not be referred to using their known names, and details about the interventions which could compromise their anonymity will also not be specified.

3.2.1 DVA recovery intervention- '*Intervention A*'

For simplicity, the DVA recovery intervention will be termed '*Intervention A*' throughout this thesis. Intervention A was a 12-week intervention, whereby weekly sessions were delivered to children aged between seven and 12 years. Children were eligible to attend if they had previously experienced DVA but were living in a safe and stable environment, which involved not living with the perpetrator nor experiencing DVA. Therefore, Intervention A was a 'late' DVA intervention as the DVA had already been experienced by the child. It was expected that children would be emotionally supported as they attended the intervention by a parent (the victim/survivor) or another family member such as a grandparent. According to the intervention manual, Intervention A was based on Peled and Davies' (1995) 'Domestic Abuse Program' which focused on healing and education for children who have experienced DVA, aiming to: 'break the secret of abuse' in children's families; help children to learn to protect themselves; enable children to experience the group as a positive and safe environment; and to strengthen children's self-esteem. Intervention A aimed to:

- i) provide a safe environment enabling children who had lived with DVA the opportunities to share their experiences and be supported;
- ii) improve children's self-esteem;
- iii) enhance children's self-protection skills;
- iv) explore a non-abusive problem-solving approach;
- v) help children have fun;

- vi) help children learn ways to express feelings;
- vii) and reduce children's feelings of isolation.

Children and parents were also given the opportunity to work through the 'Talking to my Mum' book, (Humphreys, Thiara, Skamballis, & Mullender, 2006b) a self-help intervention that was identified in Howarth et al.'s (2016) evidence synthesis of interventions delivered in the UK. In the context of Intervention A, the 'Talking to my Mum' book was presented as a child-led, optional resource that could be used in the home environment.

3.2.2 Resilience building interventions- '*Intervention B*' and '*Intervention C*'

The resilience building interventions consisted of 16 weekly sessions and targeted different ages of children and young people. '*Intervention B*' targeted children and young people aged between eight and 13 years, whilst '*Intervention C*' targeted those aged between 14 and 19 years. To be eligible to attend either intervention, children and young people had to meet at least one of the following criteria as indicated through a completing an intervention risk assessment form: previous or current experience of DVA in the family; frequent arguments or episodes of violence toward family and/or friends; Police or Social Services had been contacted due to their violent behaviour; and evidence of behavioural problems, truancy or exclusion from school. The interventions provided an opportunity for parents to complete a short task or discussion exercise with the child or young person after they completed each session. As these interventions were targeted at a range of children in relation to their experiences of DVA, they could be viewed as a 'late' intervention for those who had experienced DVA or an 'early' intervention for those at 'risk' of being involved in a DVA relationship. Interventions B and C adopted a skills-building and cognitive behavioural approach to develop behaviour change in an interactive and relaxed atmosphere. They aimed to:

- i) increase positive management of negative emotions and develop pro-social problem-solving skills;
- ii) develop self-awareness and self-control;
- i) develop core relationship skills;
- ii) improve positive core identity and self-esteem;
- iii) provide strategies to improve communication and decision-making;
- iii) and help children develop buffering skills to build resilience to the effect of DVA, particularly if the threat had not been removed from their home environment

3.3 Methodological approach of the study

Ethical approval for this study was given by the University of Liverpool Research Ethics Committee (see Appendix 1 for confirmation of ethical approval). I had intended to compare pre- intervention and post-intervention outcome data to evidence the effectiveness of the interventions. Embedded in the interventions were tools to measure outcomes and provide evaluation data. Table 3.1 indicates which tools were administered in relation to each intervention, who was invited to complete the tools, and the time point at which these tools were to be completed. The majority of these measures were routinely administered by the DVA organisation before and after the interventions were delivered, in theory, enabling comparisons between the outcomes at two different time points, the first being pre-intervention and the second being one-month post-intervention. Post-intervention outcomes were either administered by intervention facilitators visiting families and collecting the data, or by posting the measures in a self-addressed stamped envelope. However, some tools were intended to be administered during the middle of the intervention which involved facilitators visiting parents to collect this data. Whilst the DVA organisation administered the tools to children and parents, I administered one tool to children's teachers via post, in order to examine the impact of the interventions from the viewpoints of children's teachers. In order to further explore the longevity of intervention outcomes, I also administered this tool to teachers six months post-intervention. Before providing further details about accessing and collecting data, the following sub-sections outline the tools administered.

3.3.1 Tools used for all interventions

This section provides further details about the tools administered in order to establish the effectiveness of the interventions. As indicated in Table 3.1, Tool A the Strengths and Difficulties Questionnaire (SDQ; Goodman, 1997; Appendix 2), is a measure of social, emotional and behavioural functioning, and was used to assess the effectiveness of all three interventions. The SDQ uses a multi-informant approach whereby the tool can be administered as a self-report questionnaire (SDQ-S) for young people aged 11-17 years, it can be completed by a parent (SDQ- P) and by a teacher (SDQ-T) (Vaz et al., 2016). The responses for each item are grouped into one of five subscales: emotional, conduct, hyperactivity, peer relationship and prosocial. A total difficulties score is generated from these subscales. It should be noted that norms have been established for likely clinical cases, for example, those requiring further assessment and support (Goodman, Meltzer, & Bailey, 1998). The SDQ also has an impact

supplement that assesses distress, burden to others, and how long the difficulties have been present. I asked teachers to provide contextual information regarding children's school attendance, behavioural incidents and academic achievement (Appendix 3), to aid in contextualising the results from the SDQ-T.

Table 3.1: Tools used to demonstrate effectiveness of Interventions, A, B and C

Intervention	Measure	Timing of measure completion	Data source
Intervention A	Tool A: Goodman's Strengths and Difficulties Questionnaire (SDQ)	Pre- and post-intervention (all to complete one-month post, and teachers to also complete six months- post intervention)	Parent (SDQ-P) and Teacher (SDQ-T)
	Tool B: Midway review	Halfway through intervention	Parent
	Tool C: Final review	Post- intervention (within one month)	Parent
Intervention B	Tool D: Post- group evaluation questionnaire	Post- intervention (last session of intervention)	Child /young person
	Tool A: Goodman's Strengths and Difficulties Questionnaire (SDQ)	Pre- intervention and post- intervention (all to complete one-month post, and teachers to also complete six months post)	Parent (SDQ-P) and Teacher (SDQ-T)
	Tool E: Control—Individual Protective Factors Index	Pre- intervention and post- intervention (one month)	Child/ young person
	Tool F: Hare Area-Specific Self-Esteem Scale	Pre- intervention and post- intervention (one month)	Child/ young person
	Tool G: Hostility- Symptom Checklist-90	Pre- intervention and post- intervention (one month)	Child/ young person
	Tool H: Violent Intentions- Teen Conflict Survey	Pre- intervention and post- intervention (one month)	Child/ young person
	Tool I: Self-Efficacy- Teen		Child/ young

Intervention C	Conflict Survey	Pre- intervention and post- intervention (one month)	person
	Tool A: Goodman’s Strengths and Difficulties Questionnaire (SDQ)	Pre- intervention and post- intervention (all to complete one-month post, and teachers to also complete six months post)	Child (SDQ-S), Parent(SDQ-P) and Teacher (SDQ-T)
	Tool E: Control—Individual Protective Factors Index	Pre- intervention and post- intervention (one month)	Child/young person
	Tool F: Hare Area-Specific Self-Esteem Scale	Pre- intervention and post- intervention (one month)	Child/young person
	Tool G: Hostility- Symptom Checklist-90	Pre- intervention and post- intervention (one month)	Child/young person
	Tool H: Violent Intentions- Teen Conflict Survey	Pre- intervention and post- intervention (one month)	Child/young person
	Tool I: Self-Efficacy- Teen Conflict Survey	Pre- intervention and post- intervention (one month)	Child/young person
	Tool J: Positive Outlook- Individual Protective Factors Index	Pre- intervention and post- intervention (one month)	Child/young person
	Tool K: Mating Effort Scale	Pre- intervention and post- intervention (one month)	Child/young person

3.3.2 Non-standardised tools used to examine the effectiveness of

Intervention A

With regard to the additional tools used to evidence the effectiveness of Intervention A, the following three non-standardised questionnaires were used (see Appendix 4).

i) Tool B: ‘Midway review’

Tool B comprised five questions and was administered to a parent (non-perpetrator) or another appropriate family member. It asked the informant to indicate

how many intervention sessions the child had completed, whether they perceived their child to be coping in the group sessions of the intervention, whether they had noticed behavioural improvements, how well they thought the child had engaged in the group sessions, and if there were additional ways in which the child could be supported.

ii) *Tool C: 'Final review'*

Tool C also comprised five questions and was administered to a parent (non-perpetrator) or another appropriate family member. As a follow-up to Tool B, it asked the informant to provide their perceptions about whether the intervention had helped the child and the informant, whether the child's behaviour had improved due to the intervention, if the informant's relationship with the child had changed as a result of the intervention, and whether the informant required further support.

iii) *Tool D: 'Post-group evaluation questionnaire'*

Tool D was administered to children during last session of the intervention. The questionnaire asked 11 questions that invited children to respond usually through written words or by drawing a facial expression if they preferred. The questions asked children to express how they felt at the start of the intervention and at the end, whether the group had helped them to: understand their previous experiences; manage their feelings and behaviour; communicate their experiences with their family; help them identify who was responsible for the violence, and whether they knew who to speak to if they had concerns. Children were asked to specify the 'best' and 'worst' aspects of the intervention and to share any other additional information that they wanted to communicate.

3.3.3 Standardised tools used to examine the effectiveness of Interventions B and C

In addition to the SDQ, five standardised tools had been selected from Dahlberg, Toal, Swahn, and Behren's (2005) *'Compendium of Assessment Tool'*, to assess the effectiveness of Interventions B and C (see Appendix 5). Dahlberg et al. (2005) present a set of over 170 tools that can be used to evaluate interventions that prevent youth violence and measure violence-related beliefs, behaviours and influences. It was expected that these five measures would be completed by the children and young people pre-intervention and 1-month post- intervention.

i) *Tool E: Control—Individual Protective Factors Index* (Phillips & Springer, 1992; 'Control', Appendix 5). This tool measured young people's sense of

control and this had two subscales: self-efficacy and self-control. Respondents were asked to indicate how closely several statements match their feelings. A response of “YES!” indicated that the statement was ‘very true’ for them; “yes” if it was ‘somewhat true’; “no” if it was ‘somewhat false’; and “NO!” if it was ‘very false’.

- ii) Tool F: *Hare Area-Specific Self-Esteem Scale* (Hare; 1996; ‘How I feel about myself’, Appendix 5). This 10-item scale measured young people’s feelings about their worth and importance in relation to being a friend, a student, and as a family member. They were asked to indicate the extent to which they agreed or disagreed (strongly disagree; disagree; agree; strongly agree) with 10 statements.
- iii) Tool G: *Hostility- Symptom Checklist-90* (Derogatis, Rickels, & Rock, 1976; ‘How angry do you feel?’ Appendix 5). Tool G is a six-item scale which measured ‘symptoms’ of underlying hostility. Young people were asked to respond to the items in light of how often (never; once in a while; fairly often; most of time) it was likely that they engaged in certain behaviours.
- iv) Tool H: *Violent Intentions-Teen Conflict Survey* (Bosworth & Espelage, 1995; ‘Dealing with anger’, Appendix 5). Tool H is an eight-item scale and measured a young person’s intentions to use nonviolent strategies to control anger and conflict. They were asked to indicate how likely (very likely, likely, unlikely, very unlikely) they would be to adopt certain nonviolent behaviours the next time they got angry.
- v) Tool I: *Self-Efficacy- Teen Conflict Survey* (Bosworth & Espelage, 1995; ‘Managing Anger’, Appendix 5). Tool I, a five-item scale measured a young person’s confidence in their ability to control anger and resolve conflicts without using violence, by indicating how likely they would be to use certain nonviolent strategies (very confident; somewhat confident; unsure; not very confident; not at all confident).

3.3.4 Additional standardised tools used to examine the effectiveness of Intervention C

In addition to the aforementioned tools, two additional measures were used to examine the effectiveness of Intervention C (see Appendix 6).

- i) Tool J: *The Positive Outlook-Individual Protective Factors Index* (Springer & Phillips, 1992; 'Outlook on the Future', Appendix 6). Selected from Dahlberg et al.'s (2005) compendium, this six-item scale measured a young person's outlook for the future, in relation to how closely several statements matched their feelings. A response of "YES!" was selected if the statement was 'very true' for them; "yes" if it was 'somewhat true'; "no" if it was 'somewhat false'; and "NO!" if it was 'very false'.
- ii) Tool K: *Mating Effort Scale* (Rowe, Vazsonyi, & Figueredo, 1997; 'Dating', Appendix 6). This is a 10-item scale designed to evaluate young people's attitudes towards sexual competition, based on the premise that high levels of sexual competition are highly correlated with future relationship violence. Young people were invited to respond to statements regarding the extent to which they agree (strongly disagree; disagree; neither agree or disagree; agree; strongly agree).

3.4 Accessing and collecting data

As mentioned in Section 3.3, ethical approval for this study was given by the University of Liverpool Research Ethics Committee and Appendix 1 also includes participant information sheets, consent forms, and the letters to teachers. I gained consent from the DVA organisation, the children and parents (non-perpetrators) to access the outcome data collected by the DVA organisation. School teachers were only contacted if both the child and parent provided consent. Upon having consent to contact school teachers, I was provided with their name and contact details. Teachers were informed via telephone or post that I had gained parental consent and consent from the child to contact them about collecting outcome data. Teachers also received their own participant information sheet, consent form, the SDQ-T, and additional questions regarding children's school attendance, behavioural incidents and academic achievement. Teachers were informed that if they completed the pre-intervention SDQ, they would be contacted one month and six months post-intervention with an invitation to complete the follow up SDQ. Teachers were provided with a self-addressed stamped envelope so they could easily return the completed and anonymised questionnaire. In order to engage local schools, I attended a meeting with two members of the DVA organisation and we met with headteachers from local schools to explain the interventions and the importance of the evaluation, with the view that they would communicate this to their staff.

Across the three interventions, I had access to data in relation to seven different cohorts of children and young people who had attended one of the three interventions during 2014 and 2015. Across the seven cohorts, the interventions had been delivered in a group setting. I had access to evaluation data for: 14 children across three cohorts (eight females and six males) for Intervention A, 14 males across three cohorts for Intervention B, and one cohort of five children (three females and two males) for Intervention C. Across the three interventions I had access to data for 11 females and 22 males, which totalled 33 children. Across these cohorts, two children who attended Intervention A and two who attended Intervention B did not complete the intervention, and in these cases they ‘dropped out’ during the intervention. In light of the findings, these children will be referred to as having not completed the intervention. In only one case, consent had not been given for outcome data to be provided by a school teacher, as one mother did not want her child’s school to be aware that her child attended an intervention, out of concern that information about their family circumstances would be revealed by the nature of the intervention and service provider. It should be noted that there were no complete sets of outcome data for any child or young person in relation to all the tools that had been administered. All data was anonymised using case numbers. The following section discusses the findings in relation to each intervention, in light of the available data.

3.5 Available data and findings

This section discusses what data was available in relation to the tools administered for each intervention and discusses what the findings indicated.

3.5.1 Intervention A: Available data

Table 3.2 presents what data was available in relation to the tools administered to children, parents and teachers in light of Intervention A. The available data is presented with regard to number of completed tools for each child and the percentage of completed tool components (pre or post-intervention measure). It should be noted that for the SDQ-T, as long as the tools were completed pre-intervention and one-month post-intervention, thus enabling a comparison of scores, this tool was viewed as being complete as score comparisons could be made. Table 3.2 indicates that two children had not completed the intervention, and there were two cases for which Tool A had only been partially completed. In three cases (12, 13, and 14) there was no evaluation data available in relation to any of the tool components administered. The maximum amount

of available data related to the completion of three tools in relation to four children. With regard to the availability of data in relation to the tools, some key observations were that when Tool A was administered pre- and post- intervention, the percentage of available data was highest pre-intervention compared to post-intervention. With regards to the non-standardised tools, data was available in relation to Tools B and C for four children, and there was no data available in relation to Tool D for any of the 14 children. Whilst observations regarding the available data will also be discussed in relation to Interventions B and C, these figures cannot be directly compared due to variance in the number of tools administered and the number of children across intervention cohorts.

3.5.1.1 Intervention A: SDQ scores

The analysis of the SDQ scores in the current study were analysed in light of the four- fold classification, which was based on ‘cut off’ points in a British community sample (Green, McGinnity, Meltzer, Ford, & Goodman, 2005). Whilst the previous three-fold classification bandings were ‘normal’, ‘borderline’ and ‘abnormal’, the four-fold classification consisted of ‘close to average’, ‘slightly raised’, ‘high’ and ‘very high’. Table 3.3 provides an overview of the classifications in relation to interpreting the SDQ scores and it should be noted that in this study the four-fold classification was used.

With regard to the SDQs completed by parents, pre- and post-intervention SDQ data were available in only two cases (Cases 6 and 7). There had been two cases (Cases 1 and 3) for which the post-intervention SDQ had been administered to parents but were partially completed as the facilitator only photocopied half of the questionnaire. When comparing the number of completed pre- and post-intervention SDQs, there was a greater number of pre- intervention SDQs completed by parents and teachers in comparison to post-intervention SDQs. The tool for which there was the most available data was the pre-intervention SDQ completed by the teachers.

Table 3.4 presents the mean scores of the SDQs completed by parents for cases where pre-and post-intervention data were available. Parents’ mean total difficulties scores were lower post-intervention whereby they were categorised as ‘close to average’ ($M=7.00$, $SD=4.24$) compared to pre- intervention where they were categorised as ‘slightly raised’ ($M=13.50$, $SD=6.36$). Moreover, there were changes in children’s emotional, conduct, hyperactivity and peer relationship difficulties whereby the scores were lower 1-month post intervention. There were higher scores 1-month post-intervention in relation to children’s prosocial behaviour. All the pre- and post-intervention scores for the subscales scores were situated in the ‘close to average’

category, with the exception of the pre- intervention mean score for Emotional scale being within the ‘very high’ category but in the ‘slightly raised’ category post-intervention.

Table 3.2: Overview of available data for Intervention A

Case number	Tool A Pre-intervention SDQ-P	Tool A Post-intervention SDQ-P	Tool A Pre-intervention SDQ-T	Tool A Post-intervention SDQ-T, one month	Tool A Post-intervention SDQ-T, six months	Tool B	Tool C	Tool D	Number of completed tools (out of 5)
1	/	Incomplete	/	x	x	x	x	x	0
2	x	x	/	/	/	x	x	x	1
3	/	Incomplete	/	/	x	x	x	x	1
4	x	x	/	/	/	/	/	x	3
5	x	x	/	/	/	/	/	x	3
6	/	/	x	x	x	/	/	x	3
7	/	/	x	x	x	/	/	x	3
8	x	x	/	/	x	x	x	x	1
9	x	x	/	x	x	x	x	x	0
10	x	x	/	x	x	x	x	x	0
11	x	x	/	/	x	x	x	x	1
12	x	x	x	x	x	x	x	x	0
13*	x	x	x	x	x	x	x	x	0
14*	x	x	x	x	x	x	x	x	0
Tool component completion (%)	28.57	14.29	64.29	42.86	21.43	28.57	28.57	0.00	
Note: /= data available x= data unavailable *Child did not complete the intervention									

Table 3.3: SDQ score categorisation

	Original three-band categorisation			Four-band classification			
	Normal	Borderline	Abnormal	Close to average	Slightly raised (/slightly lowered)	High (/Low)	Very high (/very low)
Parent completed SDQ							
Total difficulties score	0-13	14-16	17-40	0-13	14-16	17-19	20-40
Emotional problems score	0-3	4	5-10	0-3	4	5-6	7-10
Conduct problems score	0-2	3	4-10	0-2	3	4-5	6-10
Hyperactivity score	0-5	6	7-1	0-5	6-7	8	9-10
Peer problems score	0-2	3	4-10	0-2	3	4	5-10
Prosocial score	6-10	5	0-4	8-10	7	6	0-5
Teacher completed SDQ							
Total difficulties score	0-11	12-15	16-40	0-11	12-15	16-18	19-40
Emotional problems score	0-4	5	6-10	0-3	4	5	6-0
Conduct problems score	0-2	3	4-10	0-2	3	4	5-10
Hyperactivity score	0-5	6	7-10	0-5	6-7	8	9-10
Peer problems score	0-3	4	5-10	0-2	3-4	5	6-10
Prosocial score	3-10	5	0-4	6-10	5	4	0-3
Self- completed SDQ							
Total difficulties score	0-15	16-19	20-40	0-14	15-17	18-19	20-40
Emotional problems score	0-5	6	7-10	0-4	5	6	7-10
Conduct problems score	0-3	4	5-10	0-3	4	5	6-10
Hyperactivity score	0-5	6	7-10	0-5	6	7	8-10
Peer problems score	0-3	4-5	6-10	0-2	3	4	5-10
Prosocial score	6-10	5	0-4	7-10	6	5	0-4

(table reproduced from: www.ehcap.co.uk/content/sites/ehcap/uploads/.../SDQEnglishUK4-17scoring-1.PDF)

Table 3.4: Mean SDQ-P scores for Intervention A (pre and post-intervention)

Scales	Mean (\pm SD)	Mean (\pm SD)
	Pre- intervention scores	Post - intervention scores (one month)
Overall difficulties	13.50 (\pm 6.36)	7.00 (\pm 4.24)
Emotional	6.50(\pm 0.71)	4.00 (\pm 1.41)
Conduct	2.00 (\pm 2.83)	1.50 (\pm 0.71)
Hyperactivity	3.00 (\pm 4.24)	1.00 (\pm 1.41)
Peer relationship	2.00 (\pm 0.00)	0.05 (\pm 0.71)
Prosocial	8.00 (\pm 0.00)	9.00 (\pm 0.00)

There were six cases where at least pre-and post-intervention (one month) SDQ data was completed by teachers. Table 3.5 presents these mean scores. In three of these cases (Cases 2, 4 and 5) six-month post- intervention SDQs were available and Table 3.6 presents those scores. I now discuss key observations. When comparing pre-intervention and post-intervention SDQ scores from teachers based on the six cases, the mean total difficulties score was lower one-month post- intervention ($M=10.83$, $SD=7.63$) in comparison to pre-intervention ($M=12.33$, $SD=9.71$), however both scores were categorised as being ‘close to average’. The change in scores however was reflected through decreases in mean scores post-intervention on the conduct, hyperactivity and peer-relationship scales; all pre and post-intervention scores on these scales were classified in the ‘close or average’ category. It should be noted that there were increases in post-intervention mean scores on the emotional and prosocial scales. When comparing pre- and post-intervention scores in light of the three cases (Table 3.6), whereby post- intervention data was available at both one and six months post-intervention, the mean overall difficulties score was higher at one-month post-intervention ($M=16.33$, $SD= 5.86$) compared to pre-intervention ($M=15.67$, $SD= 8.33$) and it remained the same at six months post-intervention ($M=16.33$, $SD= 4.93$). However, the overall difficulties scores remained within the ‘slightly raised’ category pre and post-intervention. Teachers’ SDQ scores for emotional distress were ‘slightly raised’ pre-intervention and one-month post-intervention but were ‘close to average’ six months post-intervention. It should also be noted that mean hyperactivity score was categorised as ‘high’ pre- intervention and was almost categorised as ‘very high’ at one and six months post-intervention. For the prosocial scale, the mean score pre-intervention was ‘slightly lowered’ but was in the ‘close to average’ category one-month and six months post-intervention. Teachers provided extra information in three cases. In

all cases, there were reported anecdotal improvements post-intervention regarding children's attendance, behaviour and having an improved academic focus.

Table 3.5: Mean SDQ-T scores for Intervention A (pre- intervention and one month post-intervention)

Scales	Mean (\pm SD)	Mean (\pm SD)
	Pre- intervention scores (Cases 2, 3, 4, 5, 8, 11)	Post- intervention scores (one month) (Cases 2, 3, 4, 5, 8, 11)
Overall difficulties	12.33 (\pm 9.71)	10.83 (\pm 7.63)
Emotional	3.50 (\pm 3.15)	3.83 (\pm 2.48)
Conduct	1.67 (\pm 2.42)	0.33 (\pm 0.52)
Hyperactivity	5.33 (\pm 4.68)	5.17(\pm 4.36)
Peer relationship	1.83 (\pm 1.72)	1.50(\pm 2.16)
Prosocial behaviour	6.33(\pm 3.01)	7.33(\pm 1.33)

Table 3.6: Mean SDQ-T scores for Intervention A (pre-intervention, one month and six months post-intervention)

Scales	Mean (\pm SD)	Mean (\pm SD)	Mean (\pm SD)
	Pre- intervention scores (Cases 2, 4, 5)	Post- intervention scores (one month) (Cases 2, 4, 5)	Post- intervention scores (six months) (Cases 2, 4, 5)
Overall difficulties	15.67 (\pm 8.33)	16.33 (\pm 5.86)	16.33 (\pm 4.93)
Emotional	3.67 (\pm 3.51)	4.33 (\pm 3.22)	3.00 (\pm 2.65)
Conduct	1.33 (\pm 1.53)	0.67(\pm 0.58)	3.00(\pm 1.73)
Hyperactivity	8.00 (\pm 3.46)	8.67(\pm 1.53)	8.67(\pm 2.31)
Peer relationship	2.67 (\pm 2.08)	2.67(\pm 2.52)	1.67 (\pm 1.56)
Prosocial behaviour	5.00(\pm 1.00)	6.00(\pm 1.00)	6.00 (\pm 1.73)

3.5.1.2 Intervention A: 'Midway' (Tool B) and 'final review' (Tool C) responses

Table 3.2 showed that there were four cases whereby data for both Tools B and C were available. Tables 3.7 and 3.8 provide a summary of parents' responses to Tool B and Tool C respectively. The responses correspond to a case number. As presented in Table 3.7 most parents reported that their child was coping to some extent with the intervention group, although one parent reported that their child had been 'upset'. Three parents reported that they had observed an improvement in their child's behaviour, which consisted of, being calmer, being more confident, sleeping better, and one parent remarked that the improvement was linked to the child openly talking about DVA at

home. However, in Case 7, it was reported that whilst the child had sleeping improvements, they experienced eating difficulties. Only two parents made responses regarding their child's engagement in the intervention whereby they engaged 'very well'. One parent suggested a need for additional requirements in light of their child struggling to engage with the 'Talking to my Mum' resource, however, they did not specify what type of additional requirement would be needed.

Table 3.7: Tool B- Summary of parents' responses

Case number	Number of sessions	How child copes in group	Behavioural improvement	Engagement in group	Additional requirements
4	5	-Coping very well - Enjoying group	-Yes -Calmer, relaxed	-Very well	-Child struggling with the 'Talking to my mum'
5	5	No response	-No	-Very well	-No response
6	5	-Child upset in group	-Yes -Talks more openly at home about DVA	-No response	-No response
7	5	-Coping very well -Child is coping better than expected	-Yes -Increased confidence -Improved sleeping -Eating difficulties	-No response	-No response

Table 3.8: Tool C- Summary of parents' response

Case number	Has intervention helped child	Has intervention helped parent	Has child's behaviour changed	Change in parent-child relationship	Further support
4	-Yes -Child knows what happened is wrong	-No response	-Improved behaviour	-No response	-No
5	No response	-Mum struggles with child's behaviour	-No response	-No response	-Requires support
6	-Child feels better	-No response	-No response	-Child is more open about their experience of DVA	-Requires support
7	-Improved confidence -Making friends	-No response	-No response	-Child is more open about their experience of DVA	-Requires support if dad pursues contact with child

With regard to Tool C, three out of four parents reported that the intervention had helped their child, whereby the child understood that DVA was 'wrong', their child 'felt better', there had been a growth in confidence and their child had made more friends. One parent expressed that their child's behaviour had improved. In Case 5, the parent had not reported improvements to their child's behaviour and expressed that they struggled in managing their child's behaviour. Two parents expressed that as a result of the group, their relationship with their child had positively changed, as their child was more open about their experiences of DVA. Three parents reported that they required further support, of which one parent specifically requested that additional support would be needed if the perpetrator pursued contact with the child.

3.5.1.3 Intervention A: Post-intervention evaluation questionnaire

No data was available in relation to Tool D. It is possible that this data had been collected by facilitators but had not been sent back to the DVA organisation. However, the DVA organisation was able to locate anonymised archival data from a previous 'historical' cohort. Table 3.9 presents responses of seven children (five males and two

females). All the children expressed that the intervention had helped them to: understand who was responsible for DVA, better understand their feelings and behaviour, and know who they could speak to if they had further concerns about DVA. The majority of children reported that they found it helpful to talk about their experiences of DVA with other children, that the intervention helped them to understand their past experiences of DVA and talk to their mothers. Whilst none of the children specified the ‘worst’ thing that happened at the intervention, the majority of children reported that meeting new friends was the ‘best’ thing, and one child specifically named another child in their response. Across the cohort, children experienced a range of emotions when reflecting upon how they felt at the beginning of the intervention, and with the exception of one child, all children expressed being sad at the end of the intervention. Whilst four children did not provide any additional comments, one child reported that they would specifically miss the “*teachers*” of the intervention, one child said that they felt sad and would miss “*everyone*”, and one child expressed that they had enjoyed playing with a specific child. Responses made post-intervention could not be compared with responses made pre-intervention, as no corresponding tool had been designed.

3.5.2 Intervention B

Out of a total of 14 children, there were two cases for which there was no evaluation data available at all in relation to any tool components (see Table 3.10, Cases 19 and 28), and in six cases no tools had been fully completed. Out of seven tools the highest number of completed tools was two.

3.5.2.1 Intervention B: SDQ scores

Pre- intervention SDQs completed by parents and teachers were the most frequent form of available data in comparison to post-intervention SDQs. Of the eight cases where pre-intervention SDQs were completed by parents and/or teachers, one month-post intervention SDQs were only available in six of these cases. It should be noted that there was an absence of post- intervention data completed by teachers at six months. In two out of eight cases, only pre-and post-intervention SDQs were completed by the parent (Cases 18 and 24). In four cases out of eight, pre-and post SDQs had only been completed by teachers (Cases, 15, 16, 22, and 23) and in the remaining two cases, pre-and post (one month) SDQs had been completed by both parents and teachers (Cases 17 and 21).

Table 3.9: Tool D- Summary of responses from historical cohort

Feelings at the start of the intervention	Feelings at the end of the intervention	Has intervention helped to understand the 'past'	Has intervention helped child to talk to mum	Best thing that happened	Worst thing that happened	Has intervention helped in understanding who was responsible for DVA	Has it helped to talk to other children about DVA	Has intervention helped feelings and behaviour	Does child know who talk to if worried	Additional comments
Fine (n=1)	Sad (n=4)	Yes (n=6)	No (n=1)	Everything (n=1)	Nothing (n=6)	Yes (n=7)	Yes (n=6)	Yes (n=7)	Yes (n=7)	No (n=4)
Nervous (n=2)	Sad face (n=2)	Kind of (n=1)	Yes (n=5)	Meeting new friends (n=6)	No response (n=1)		Kind of (n=1)			Will miss 'teachers' (n=1)
Sad face	Smiley face (n=1)		Sometimes (n=1)							Enjoyed playing with another child (n=1)
Smiley face (n=2)										
Neural face (n=1)										Feeling sad and will miss everyone (n=1)

Table 3.10: Overview of available data for Intervention B

Case N	Tool A Pre- intervention SDQ-P	Tool A Post- intervention SDQ-P	Tool A Pre- intervention SDQ-T	Tool A Post- intervention SDQ-T, one month	Tool A Post- intervention SDQ-T, six months	Tools E, F, G, H, I Pre- intervention	Tools E, F, G, H, I Post- intervention	Number of completed tools (out of 7)
15*	/	x	/	/	x	x	x	1
16*	/	x	/	/	x	x	x	1
17	/	/	/	/	x	x	x	2
18	/	/	x	x	x	x	x	1
19	x	x	x	x	x	x	x	0
20	x	/	x	x	x	x	x	0
21	/	/	/	/	x	x	x	2
22	x	x	/	/	x	x	x	1
23	x	x	/	/	x	x	x	1
24	/	/	x	x	x	x	x	1
25	x	/	x	x	x	x	x	0
26	/	x	/	x	x	x	x	0
27	/	x	/	x	x	x	x	0
28	x	x	x	x	x	x	x	0
Tool component completion (%)	57.14	42.86	57.14	42.86	0.00	0.00	0.00	
<div> <div>/= data available intervention</div> <div>x= data unavailable</div> <div>*Child did not complete the</div> </div>								

Table 3.11 and Table 3.12 show that there were changes in parents' and teachers' mean SDQ scores over time. Both parent and teacher total difficulties scores decreased when comparing pre- intervention scores. The total difficulties scores reported by parents were categorised as 'very high' pre-intervention ($M=29.50$, $SD=6.36$) and 'slightly raised' at one-month post-intervention ($M=15.50$, $SD=6.36$). Whilst total difficulties scores reported by teachers decreased one month- post -intervention ($M=19.83$, $SD=7.11$) compared to pre-intervention ($M=22.17$, $SD=6.27$), the scores were still categorised as 'very high'. Parents' scores for emotional and conduct scales were categorised as 'very high' pre-intervention but were categorised as 'slightly raised and 'high' respectively post-intervention. Mean hyperactivity scores were categorised as 'very high' pre-intervention and were categorised as 'high' post-intervention. Parents' scores for peer relationship difficulties were categorised as 'very high' pre-intervention and were 'high' post-intervention. The mean prosocial scale score was categorised as 'slightly lowered' pre-intervention and 'close to average' post-intervention. In relation to teacher's reported scores, the total difficulties mean score was in the 'very high' category both pre-intervention and one-month post intervention, although the mean score had decreased post-intervention. Whilst there was an increase in peer-relationship problems, the mean score was 'slightly raised' both pre and post-intervention. Scores for emotional difficulties, conduct, hyperactivity and prosocial scales had improved, but no scores were located in the 'close to average' category.

Table 3.11: Mean SDQ-P scores for Intervention B- Cases 17, 18, 21, 24

Scales	Mean (\pm SD)	Mean (\pm SD)
	Pre- intervention scores	Post intervention scores (one month)
Total difficulties score	29.50 (\pm 6.36)	15.50 (\pm 6.36)
Emotional	8.00 (\pm 1.41)	3.50 (\pm 2.12)
Conduct	7.00 (\pm 1.41)	3.50 (\pm 0.71)
Hyperactivity	8.50 (\pm 2.12)	4.50 (\pm 2.12)
Peer relationship	6.00 (\pm 1.41)	4.00 (\pm 1.41)
Prosocial behaviours	6.50 (\pm 3.54)	7.50 (\pm 2.12)

Table 3.12: Mean SDQ-T scores for Intervention B- Cases 15, 16, 17, 21, 22, and 23

Scales	Mean (\pm SD)	Mean (\pm SD)
	Pre- intervention scores	Post- intervention scores (one month)
Total difficulties score	22.17 (\pm 6.27)	19.83 (\pm 7.11)
Emotional	5.33 (\pm 3.14)	4.17 (\pm 2.14)
Conduct	5.00 (\pm 1.55)	4.67 (\pm 3.20)
Hyperactivity	8.50 (\pm 2.35)	7.50 (\pm 2.43)
Peer relationship	3.33 (\pm 2.16)	3.50 (\pm 2.51)
Prosocial behaviour	3.83 (\pm 1.60)	4.33 (\pm 2.88)

3.5.2.2 Intervention B: Tools E, F, G, H, and I

There was no data available in relation to Tools E, F, G, H, and I. There were difficulties in accessing a full set of archival data for these tools.

3.5.3 Intervention C

Demonstrating the effectiveness of Intervention C involved administering the highest number of tools. Pre-and post (one month) SDQs completed by parents and teachers were the most frequent form of data across this dataset (Table 3.13). There was 100% data available for pre-intervention and one- month post-intervention SDQs completed by parents and teachers, however there was an absence of data provided by teachers six months post- intervention. However out of a total of ten tools, the highest number of completed tools was three.

3.5.3.1 Intervention C: SDQ scores

There were two cases for which pre-and post-intervention SDQ data had been completed by the child, parent and teacher (Cases 30 and 31).

Table 3.13: Overview of available data for Intervention C

Case N	Tool A Pre- interventi on SDQ-S	Tool A Post- intervention SDQ-S	Tool A Pre- intervention SDQ-P	Tool A Post- intervention SDQ-P	Tool A Pre- intervention SDQ-T	Tool A Post- intervention SDQ-T, one month	Tool A Post- intervention SDQ-T, six months	Tools E, F, G, H, I, J, K Pre- intervention	Tools E, F, G, H, I, J, K Post- intervention	Number of completed tools (out of 10)
29	/	x	/	/	/	/	x	x	x	2
30	/	/	/	/	/	/	x	/	x	3
31	/	/	/	/	/	/	x	/	x	3
32	x	x	/	/	/	/	x	/	x	2
33	x	x	/	/	/	/	x	/	x	2
Tool component completion (%)	60.00	40.00	100.00	100.00	100.00	100.00	0.00	80.00	0.00	
/= data available			x= data unavailable			*Child did not complete the intervention				

Table 3.14 presents children's self-reported pre- and post-intervention SDQ scores. Children reported a decrease in overall difficulties when comparing pre-intervention ($M=23.00$, $SD=1.41$), and post intervention scores ($M=19.50$, $SD=2.12$), although the post-intervention score remained 'very high'. Post- intervention scores had improved in relation to the emotional scale, as they were 'high' pre-intervention and 'close to average' post-intervention. Whilst scores decreased post-intervention with regard to the hyperactivity scales and peer relationship difficulties, they did not indicate a change in categorisation. The mean conduct score remained the same post-intervention. The mean prosocial score pre-intervention was categorised as 'low' and post-intervention was categorised as 'very low'.

Table 3.14: Mean SDQ-S scores for Intervention C- Cases 30 and 32

Scales	Mean (\pm SD)	Mean (\pm SD)
	Pre- intervention scores	Post- intervention scores (one month)
Total difficulties score	23.00(\pm 1.41)	19.50(\pm 2.12)
Emotional	6.00 (\pm 2.83)	3.50 (\pm 0.71)
Conduct	5.50 (\pm 2.12)	5.50 (\pm 2.12)
Hyperactivity	9.50 (\pm 0.71)	9.00 (\pm 1.41)
Peer relationship	2.00 (\pm 0.00)	1.00 (\pm 0.00)
Prosocial	5.50 (\pm 2.12)	2.50 (\pm 2.12)

Changes were also observed in parents' pre- and post-intervention SDQ scores (Table 3.15). At one-month post-intervention there was a decrease in overall difficulties whereby the mean total difficulties score was classified as 'very high' pre-intervention ($M=27.00$, $SD=4.24$) whilst it was categorised as 'high' post-intervention ($M=18.25$, $SD=7.50$). The mean scores for all subscales decreased post-intervention.

Table 3.15: Mean SDQ-P scores for Intervention C- Cases 29, 30, 31, 32, 33

Scales	Mean (\pm SD) Pre-intervention SDQ scores	Mean (\pm SD) Post intervention SDQ scores (one month)
Total difficulties score	17.80 (\pm 7.79)	11.80 (\pm 5.68)
Emotional	3.40 (\pm 3.72)	2.00 (\pm 2.12)
Conduct	4.20 (\pm 3.70)	2.60 (\pm 1.82)
Hyperactivity	8.20 (\pm 1.30)	5.80 (\pm 1.10)
Peer relationship	2.00(\pm 1.73)	1.40 (\pm 2.61)
Prosocial	5.80 (\pm 2.95)	7.40 (\pm 3.65)

As presented in Table 3.16, the total difficulties scores reported by teachers was categorised as ‘high’ pre-intervention ($M=17.80$, $SD=7.79$) but had decreased post-intervention, categorised as ‘slightly raised’ ($M=11.80$, $SD=5.68$). The mean scores of the subscales had all improved post-intervention. Only two teachers provided extra information about children’s school attendance, behavioural incidents and academic achievement. In one case there was a reported improvement post-intervention in the child’s behaviour, school attendance, and the child being ‘on track’ in reaching their academic targets. In another case, no behavioural incidents or concerns with attendance or academic achievement were reported at either pre-intervention or post- intervention.

Table 3.16: Mean SDQ-T scores for Intervention C- Cases, 29, 30, 31, 32, 33

Scales	Mean (\pm SD) Pre- intervention scores	Mean (\pm SD) Post- intervention scores (one month)
Total difficulties score	27.00 (\pm 4.24)	18.25(\pm 7.50)
Emotional	6.50(\pm 2.38)	4.25(\pm 2.22)
Conduct	7.50(\pm 2.08)	5.50(\pm 2.38)
Hyperactivity	8.75(\pm 1.50)	5.50(\pm 4.12)
Peer relationship	4.25(\pm 1.50)	3.00(\pm 2.16)
Prosocial behaviour	5.00(\pm 1.16)	4.25(\pm 0.96)

3.5.3.2 Intervention C: Tools E-K

In four cases, children had completed Tools E, F, G, H, I, J, and K but only completed these tools pre-intervention and unfortunately no post- intervention data was available. This therefore prevented pre- and post- intervention comparisons of these tools. However, in order to gauge pre- intervention scores on these scales, the pre-intervention mean scores were calculated and viewed in light of the expected norm scores.

For Tool E, the maximum obtainable score of 52 would indicate a high sense of self-control, whilst a minimum score of 13 would indicate a relatively low sense of control. From the available data, a mean score ($M=35.25$, $SD=3.20$) was calculated, indicating that young people had a ‘higher’ level of conflict resolution skills. For Tool F, the intended range (norm) is between one and four, with a high score indicating a greater feeling of self-worth. In the current study the mean score ($M=2.03$, $SD=0.22$) was in the ‘intended’ range. For Tool G, the, the intended range of scores is between one and four, whereby a higher score indicates more hostility. The calculated mean score was observed as reaching towards a mid- point ($M=1.83$, $SD=17.00$). For Tool H, there is a possible score range between eight and 32, whereby high scores indicate a stronger intention to use non-violent strategies. In the current study, the mean score ($M=14.75$, $SD=3.80$) did not indicate a strong intention from young people to use non-violent strategies. For Tool I, the intended range is one to four, with a high score indicating a greater feeling of confidence. The mean score ($M=2.10$, $SD=0.22$), indicated ‘medium’ levels of confidence. Tool J was scored out of 24, whereby a minimum score of 6 indicates a relatively negative outlook. In this study, the mean score ($M=22.00$, $SD=2.71$) indicated that young people had a higher positive outlook than negative. For Tool K, the mean MES score was calculated and compared to the mean score as reported by Rowe et al. (1997). In the current study the mean score of boys ($M=29.00$, $SD=8.49$) was higher than girls ($M=27.50$, $SD=4.95$) suggesting that boys had slightly higher levels of sexual competition. This indicated a similar observation to that made by Rowe et al. (1997) whereby girls had lower mean scores than boys (Boys: $M=27.2$, $SD=6.5$; Girls; $M=22.2$, $SD=4.7$). However, making a direct comparison between the scores from the current study and Rowe at al.’s (1997) study is limited due to demographic differences including age, and the larger sample size of Rowe et al.’s (1997) study ($N=232$; 120 boys and 112 girls).

3.6 Lessons learned and implications of the study

It has been proposed that documenting the ‘lessons learned’ from intervention evaluation research is invaluable for developing the intervention evidence base for children who have experienced DVA (Rizo et al., 2011). In light of this, and due to the current underdeveloped evidence base for such interventions as highlighted by Howarth et al. (2016) this section documents important observations and lessons learned from this study.

3.6.1 The implications of the design of Study 1

Due to the small amount of available evaluation data in relation to all of the interventions, no conclusions can be drawn about the effectiveness of the interventions. In cases where comparisons could be made between pre- and post-intervention outcomes, and where there had been positive score changes over time, the extent to which these differences were statistically significant could not be established. Having more pre- and post-intervention data to compare would have provided a clearer indication about the significance of these differences and might have enabled the DVA organisation to present more robust evidence about the effectiveness of the service they were delivering.

Adopting a pre- and post -intervention outcome study design has been observed as commonplace when evaluating interventions for children who have experienced DVA (Howarth et al., 2016). This seemed the most viable way to evaluate the interventions, given the anticipated available data and as efforts were made to pursue some type of follow-up of outcomes post-intervention, which has been recognised as lacking in previous evaluation studies (Graham-Bermann, 2001). Whilst a longer follow-up at 12 months or more could have been attempted, it is recognised that the observations made about the outcomes post-intervention were only measuring ‘short- term’ outcomes.

There were further limitations of this study arising from the lack of a comparison group. Outcome comparisons could have been made in a number of ways, such as comparing outcomes between children who completed the intervention and those who did not, comparing the group and one-to-one format of the interventions, as well as making comparisons with a control group. With hindsight, a control group for each intervention could have been developed through a waitlist control, although the unpredictable nature of relying upon waiting list samples in practice may have posed barriers. In light of having no comparison group, there were difficulties in discerning the benefits of attending an intervention (Graham-Bermann, 2000).

3.6.2 The limitations of the outcome measures

There are lessons to be learned regarding the outcome measures that were selected to provide evidence about the interventions’ effectiveness. If all pre and post-intervention data had been available, directly comparing outcome scores alone would not have accounted for contextual factors influencing these outcomes and how these outcomes were reported (Bamberger, 2012). For example, there may have been a number of intervention related factors that influenced outcomes, such as the quality of the intervention delivery, as well as factors external to the intervention for example,

family circumstances. Trying to interpret outcomes without understanding the wider context in which the outcomes were situated presented limitations about what could be concluded about intervention effectiveness. With hindsight, I could have collected and analysed routine data and case notes written by intervention facilitators to examine whether this provided a better understanding of outcomes, thus triangulating the data. It has been proposed that using routine service data, and informal and anecdotal data may facilitate a better understanding of intervention outcomes (Howarth et al., 2016). The call for the collection and better use of routine data is also in line with the recommendation by NICE (2014), whereby consideration should be made towards identifying the most appropriate ways to collect and manage DVA related data across the sectors of health and social-care and criminal justice.

Routine data for example could have been used to assess whether there was any relationship between children's attendance and/or parents' attendance at parent sessions and intervention outcomes. Whilst I had attempted to contextualise the outcomes by providing teachers with an opportunity to provide further information about children's school attendance, behaviour and academic achievement, these opportunities were not commonly taken up.

3.6.2.1 Limitations of the standardised tools

There are advantages of using standardised tools to assess intervention effectiveness. These include, having a recognised method to gauge impact, knowing the reliability and validity of tools, and providing empirical data to support evidence-based practice (McConnell & Taylor, 2016). In the current study there were a range of standardised tools used across the interventions. As most of the data available corresponded to Tool A (the SDQ) and was used to assess effectiveness of all three interventions amongst multiple informants, I primarily focus on critiquing Tool A.

The SDQ is widely used in the UK and internationally, in both low and high-income settings (Achenbach et al., 2008; Goodman & Goodman, 2009; Klasen et al., 2000; Mojtabai, 2006; Mullick & Goodman, 2001; Obel et al., 2004). It is used as a screening tool in order to establish the prevalence of mental health difficulties, investigate symptom development, examine the effectiveness of interventions and to monitor clinical outcomes (Fink et al., 2015; Wigelsworth, Humphrey, & Lendrum, 2011; Wolpert, Cheng, & Deighton, 2015). Wolpert et al.'s (2015) review of four child-reported outcome measures compared the SDQ, the Revised Child Anxiety and Depression Scale (RCADS; Chorpita, Yim, Moffitt, Umemoto, & Francis, 2000), the (Child) Outcomes Ratings Scale (C/ORS; (Duncan, Miller, & Sparks, 2003) and Goals

Based Outcomes (GBO; Law, 2013). It was argued that across its versions, the SDQ was the most well-validated measure, and had the greatest evidence for its use in service evaluation compared to the remaining three measures. However, Wolpert et al. (2015) identified that clinicians often reported that the 'broad' nature of the SDQ did not always provide enough detail to clinicians about issues relevant to a specific case. The SDQ has often been used in evaluations of interventions for children who have experienced DVA (Howarth et al., 2016), and therefore it was not surprising that the tool was used in relation to assessing the effectiveness of Intervention A, B and C. However, given the broad nature of the tool, it could be questioned as to whether it was appropriate to use the tool as the primary standardised measure for evidencing the effectiveness of Intervention A, and in light of the specific aims of Intervention A.

Other literature has shown a lack of consensus regarding the psychometric properties of the SDQ (Di Riso et al., 2010; Hagquist, 2007; McCrory & Layte, 2012) and the uncertainty about how the SDQ scales can be interpreted. For example, across the child, parent and teacher versions of the SDQ, the five-factor and three-factor models have been used to interpret results (Goodman, Lamping, & Ploubidis, 2010). Whilst the five-factor model contains the factors of emotional problems, conduct problems, hyperactivity, peer problems, and prosocial behaviour, the 3-factor model uses the factors of internalizing problems (a combination of emotional and peer problems), externalizing problems (a combination of conduct problems and hyperactivity), and prosocial behaviour. Although there has been evidence to suggest that both models are an acceptable fit (Di Riso et al., 2010; Goodman et al., 2010), there is also evidence to suggest that individual items may lack measurement invariance based on either cultural specific factors (Ortuno-Sierra et al., 2015) or time factors (Hagquist, 2007). In a recent study, DeVries, Gebhardt, and Voß (2017) concluded that further work was still needed to assess measurement invariance across cultures.

It has been also argued that the SDQ works best when it is completed by all three informants, namely parents, teachers and young people (Goodman, Ford, Simmons, Gatward, & Meltzer, 2000). If data cannot be obtained from all informants, parents' and teachers' reports have been shown to have equal predictive value. However, in Stone, Otten, Engels, Vermulst, and Janssen's (2010) review on the psychometric properties of the SDQ, they reported poor to moderate weighted mean parent-teacher (inter-rater) agreement correlations. Even when attempts were made to reduce informant discrepancies (through mitigation by a senior clinician), ratings were at best in modest levels of agreement (Nguyen et al., 1994). As Vaz et al. (2016) have argued, the

disagreements between parents' and teachers' ratings of a child's behaviour could be explained by how children behave differently in different contexts (Strickland, Hopkins, & Keenan, 2012; Youngstrom, Loeber, Stouthamer-Loeber, 2000). It is also likely that parents and teachers use different benchmarks when evaluating these behaviours. For example, parents may compare behaviour to that of children's siblings, whilst teachers may compare a child to other children in the class of which their comparison may involve a more diverse group (Strickland et al., 2012).

In light of the mixed evidence regarding the psychometric properties of the SDQ, even if more pre- and post-data had been available, the tool would have been limited in establishing firm conclusions about the effectiveness of the interventions. Making direct comparisons between the scores reported by children, parents and teachers would have had limitations, as informants' responses may have been influenced by different perceptions, which would have benefitted from further exploration in order to aid the interpretation of the scores.

3.6.2.2 Limitations of non- standardised tools

In previous evaluation studies of interventions for children who have experienced DVA, non-standardised tools have been used to assess child and parental perceptions of the impact of an intervention on outcomes (Howarth et al., 2016). In the current study, three non-standardised tools (Tools, B, C, and D) were used to assess Intervention A. It might be expected that the non-standardised tools would have attempted to measure outcomes that were not captured in standardised tools. For example, as one of the outcomes of Intervention A was to increase children's self-esteem, it might have been anticipated that the non-standardised tools attempted to measure self-esteem. As this was not the case, this questions what role the non-standardised tools had, and whether they were more suited to informing the development of the interventions rather than measuring outcomes.

It was expected that Tool B would be completed as children were halfway through the intervention and Tool C would be completed within one month of the intervention ending. It might have been expected that these tools would have explored similar outcomes to facilitate a comparison. However, the majority of questions did not correspond between Tools B and C which limited the extent to which the responses could be compared. As four out of five questions in Tool B and all five questions in Tool C were framed as closed questions, the type of questions asked posed limitations on what type of responses could be elicited. With regard to the questions asked in Tool D, nine out of the 11 questions were closed questions, which again limited the nature of the

responses given. Whilst the final question, *'Is there anything else that you would like to tell us?'* may have intended to encourage a range of answers, it may have been unclear as to what the question was asking and therefore, minimal responses were given.

3.6.3 Experiencing missing data

Previous studies have reported the challenges associated with experiencing missing evaluation data when trying to evidence the effectiveness of interventions for children who have experienced DVA (Kot, 1996; McWhirter, 2011; Nolas, Neville, & Sanders-McDonagh 2012; Wager & Rodway, 1995). In one study which experienced difficulties in reaching complete sets of pre- and post-intervention outcome data for 36 children, it was reported that the level of sophisticated data analysis was limited and it was not possible that conventional methods of assuming values for missing data were valid (Nolas et al., 2012). Whilst discussions might be had with regard to the implications of missing data on data interpretation, there has been limited discussion in the DVA literature about the possible reasons for explaining missing data in intervention evaluation studies.

In the current study, the tools administered to children were embedded in intervention delivery. However, pre- intervention data was not available in all instances. It is possible that children or parents may have been absent when the tools were administered and their completion of the tool was not followed up. It is also possible that there was little initiative to engage with the tools. Furthermore, the lack of post-intervention data in comparison to pre-intervention data in the current study could be related to how the purpose of completing the tools was viewed, thus contributing to a lack of engagement (McConnell & Taylor, 2016). In the current study it was observed that when data was meant to be collected at the end or after an intervention, less data was available. This raises questions about whether the context and timing of when tools were administered and when they were to be completed played a role in influencing engagement in evaluation. Moreover, the time taken for individuals to complete the different tools and the method used in returning these to the DVA organisation may have posed a barrier to their completion.

Another factor to consider is the role of intervention facilitators in ensuring the collection of evaluation data. As many facilitators were employed by other organisations, there may have been obstacles preventing either the collection of data or promptly disseminating the evaluation data to the DVA organisation. The prioritisation of the distribution, collection and monitoring of evaluation data may have been challenging given facilitators' other responsibilities, meaning that data was not easily

accessible to the DVA organisation. Previous research in the context of DVA perpetrator programmes has discussed intervention facilitators' views about the use of standardised measures and balancing their advantages in demonstrating interventions effectiveness with issues of concern. Concerns identified by facilitators related to the impact of evaluation on programme delivery, an inability to tailor to the programme, impacting engagement with the programme, the impact on the practitioner and service user relationship, and confusion about their role and use within practice (McConnell & Taylor, 2016). Thus, there are important factors to consider in light of understanding the context within which limited available data is situated.

It was expected that Tool D would have been completed by the children at the end of Intervention A. As this tool was routinely administered during the last session of the intervention, there may be a number of reasons as to why there had been a lack of data available. If a child had been absent from the last session, there may have been no other opportunities to complete it, or if they were asked to complete it after the intervention had ended, they may have been disinterested. Using the example of this tool, it can be questioned as to whether the value of the voice of the child can play a role in both contributing to evaluation data, and in the design of tools used in evaluation studies. This is especially relevant in light of the observations made in Chapter 2, concerning how much of the research on children's experiences of DVA and interventions is largely adult-informed. Thus, when considering engagement in evaluation, listening to the voices of those who are expected to participate in providing the data as well as those of children, could identify barriers to engagement. Moreover, recognising how individuals understand the relevance of these tools, what outcomes are viewed as important and the logistical issues of how and when measures are administered, could make valuable contributions to developing evaluation methods and facilitating engagement. This may also provide useful recommendations for how a DVA organisation might best communicate the importance of evaluation.

As mentioned earlier in this chapter, there was one instance when parental consent was not given for data to be collected from a school teacher, in order to prevent the school from learning about the family circumstances associated with DVA. Whilst this could have implications on comparing outcomes as reported by multiple informants, this also raises broader questions about the extent to which multi-agency support can be provided to the child. This also requires important discussions about how to engage with a range of stakeholders in providing evaluation data if parental consent is not given. Although I had attempted to encourage engagement with school teachers via head

teachers, it is unclear whether this was an effective method of engaging with teachers. However, at the time it seemed to be an opportunity worth exploring.

As Howarth et al. (2016) recommended, identifying the practical barriers contributing to the underdeveloped evidence base for intervention for children who have experienced DVA is paramount in order to consider what responses can be made. It is important to acknowledge the difficulties and challenges of collecting and monitoring pre-and post-intervention data, especially when relying on this approach to demonstrate intervention effectiveness. Identifying the challenges of this would not only facilitate our understanding of the evaluation landscape, but it may also present possible solutions.

Upon reflection, I recognise that the limitations and problems experienced in Study 1, such as the large volume of missing data, might have been avoided by consulting with child and adult stakeholders. Prior discussion with the professionals might have identified the issues they were experiencing with data collection and highlighted the barriers to relying on this data for my thesis. In addition, discussing with children and parents in advance of the study both their views on this data and how they would like the study to be shaped might have resulted in a very different study design. Engaging stakeholders in this way is also known as public and patient involvement (PPI). PPI usually consists of contributors who have a direct personal experience of the condition being investigated, or bring general experience of being a patient or service user. PPI contributors are recognised in the UK and internationally as being invaluable to informing the planning, design and implementation of research (including intervention evaluation trials) as they provide a “*distinctive perspective to researchers or clinicians*” (Kearney et al., 2017 p.1401). With hindsight, I could have invited intervention recipients and providers to participate in this way.

3.6.4 Developing a taxonomy of interventions

Whilst the effectiveness of the three interventions could not be concluded based on this study, further consideration should be given to the complexities associated with assessing intervention effectiveness. Abraham and Michie (2008) suggested that it becomes challenging to replicate effective interventions and to identify what factors have contributed to intervention effectiveness if there is an absence of standardised vocabulary that clearly defines intervention components. Specifically, this argument was given within the context of developing a taxonomy of behavioural change techniques and being able to test theories of change. However, inadequate specification about interventions may lead to ambiguities concerning how differences in intervention content can impact intervention effectiveness. It is noted that in the write up of this

study, the documentation of intervention specifications was limited for anonymity purposes. However, there may be additional intervention characteristics that may impact outcomes for any intervention, including, audience characteristics, the mode of intervention delivery, types of intervention materials, the extent in which there is fidelity of intervention implementation in relation to the manual specifications, and how interventions are tailored to individuals or certain groups. Wells, Williams, Treweek, Coyle, & Taylor (2012) have proposed that developing a taxonomy of complexity could be helpful for reflecting the range of contextual influences that can impact outcomes of complex interventions. I came to realise that Interventions A, B, and C were complex interventions as defined in Chapter 1. Whilst Wells et al. (2012) suggested that a taxonomy of complexity would be helpful in light of conducting RCTs, this consideration may also be helpful in non-RCT studies, as there may be essential features of interventions that influence outcomes. Schulz, Altman, and Moher (2010) proposed that intervention features could fall into two broad categories, the first being treatment delivery characteristics, and the second being intervention content. Identifying the role of factors within these categories could present potential threats to intervention fidelity and standardisation, as well as assessing their relationship to outcomes. When considering this in light of the current study, one notable example of how an intervention related characteristic may have impacted outcomes was the utilisation of the ‘Talking to my Mum’ book, an optional resource used alongside Intervention A. Its utilisation was not monitored nor accounted for when considering the effectiveness of Intervention A. In relation to all the interventions, the extent to which parents attended the parent sessions and engaged with the interventions may have also impacted the outcomes.

Wells et al. (2012) suggested that other contextual factors which may impact outcomes may include the influence of organisational structure, culture and resources. When reflecting upon the range of factors which can impact intervention outcomes light of the current study, understanding the context of practice in which an intervention is situated holds importance for interpreting outcomes. In turn, multiple methods, sources and perspectives need to be incorporated in order to adequately reflect the context of practice and to robustly assess intervention effectiveness.

3.7 Chapter summary

It has been important to acknowledge the lessons learned and implications arising from Study 1. This chapter raises questions about what data should be collected, when it should be collected and what methods and tools can best be used to assess the

effectiveness of interventions. Study 1 also underlines the importance of ensuring that if evaluation data is to be gathered by a service, the data collectors need to understand the significance of robust and comprehensive data collection, particularly as evaluation is becoming increasingly important to sustain and inform service provision. This chapter has also recognised how a strong PPI contribution might have helped to address some of the problems that were experienced in the study. These issues will be further explored in the Discussion. Due to the limitations of the available data, the tools used to assess intervention effectiveness, and as a response to the lessons learned from this first study, I came to realise that its limitations raised more questions than it answered. Bearing this in mind, I planned to undertake a qualitative study in order to understand the perspectives of people involved in delivering and receiving the interventions. The following chapter introduces this subsequent study.

Chapter 4: Study 2- The qualitative study

4.1 Introduction

The previous chapter focused on the study which I had originally anticipated would form the basis of my PhD. As it became clear that the data was not good enough to assess the effectiveness of Interventions A, B and C, I decided to conduct a qualitative study involving the people who received or delivered the interventions. In designing this study, I was keen to involve the children who had attended the interventions as well as their parents and the intervention providers. For simplicity, the term ‘intervention providers’ refers to the collective group of individuals who played a role in the provision, delivery, coordination and/or development any of the three DVA interventions. This chapter describes the theoretical background of Study 2 and the choice of methods used. It also explores the ethical considerations of this work and the limitations of the study.

4.2 Aims of the study

The aims of Study 2 were as follows:

- i) To examine the experiences of individuals who receive and deliver interventions targeted at children and young people who have experienced DVA
- ii) To identify the difficulties of demonstrating the effectiveness of interventions targeted at children and young people who have experienced DVA

4.3 Theoretical background

Before beginning this new study, it was essential to establish my theoretical position as a researcher. This section discusses the theoretical stance I took in the development of Study 2 and its undertaking.

Ontology has been defined as the theory of existence, or, the science or study of being, asking what the nature of reality is. Blaikie (1993) proposed that this definition includes the claims made by a particular approach to social enquiry and the nature of social reality. Linked with ontology, epistemology is concerned with what counts as knowledge, asking what it is that we can claim to know (King & Horrocks, 2010). As

our ontological understanding directly influences what we claim to be knowledge, ontology and epistemology are interconnected.

Ontological positions are usually described as realist or relativist. A realist or positivist position views the world as being predictable, law-based and asserts that a real world exists independently from human experience. Its epistemological standpoint requires knowledge to be observable and testable through hypothesis testing, and free from human subjectivity and bias (Keat, 1979). As a result, the researcher is placed outside of what they are researching or observing. In contrast, a relativist or subjectivist position assumes that there is no real world that exists independently of human experience, and that social reality and the world are relative. An epistemological standpoint allied with this ontological position is constructivism, whereby knowing and learning are embedded in social life and social reality consists only of the meanings made by individuals who create their reality (Crotty, 1998).

Another closely related epistemological standpoint to the relativist position is interpretivism, whereby interpretation is emphasised as a means by which to understand the world (Crotty, 1998). Interpretivism acknowledges the influence of a range of factors such as cultural, historical or psychological influences, which can have significance in shaping how people understand the world. There is an overlap between constructivism and interpretivism, as both seek to understand meaning, experiences, and how human behaviour can be interpreted, whilst recognising that these are bound by time and context (Hudson & Ozanne, 1988). However, critics of interpretivism have argued that by privileging individuals' agency, little attention is given to the means by which social phenomena are created and embedded, which is fundamental to an understanding of constructivism (Crotty, 1998; Wainwright & Forbes, 2000). In contrast to the epistemological position of objectivism which emphasises that there is only one unique truth to discover, interpretivist and constructivist positions assert that there are multiple truths. Rather than being dichotomous, these ontological and epistemological standpoints can be viewed as a continuum (Morgan & Smircich, 1980).

4.3.1 Ontology and epistemology of the study

The aim of the study was to explore the experiences of children, parents and intervention providers in relation to the interventions and identify the difficulties of evidencing intervention effectiveness. In light of this, I believed that there was something important to be understood about the experiences of these individuals, even though how this was understood would be influenced by the social and cultural lenses worn by myself and the participants. Therefore, I rejected both the pure realist and the

relativist stance and instead, I took a position that was more closely aligned with critical realism, in contrast with the stronger realist position I had adopted when undertaking Study 1.

The perspective of critical realism is one that blurs the distinction between the realist and relativist positions, as elements of realism and relativism are retained (Bhasker; 1998; 2008; Willig, 1999). Critical realist research aims to “*provide causal explanations rather than predictions, of how and why events occur*” (Hu, 2018, p. 122). Whilst critical realism rejects the idea of ‘multiple realities’ whereby individuals or societies socially construct independent worlds, critical realism does acknowledge that there are different yet valid perspectives about ‘reality’ (Wiltshire, 2018). Thus, critical realism recognises that there is an independent reality as well as a subjective interpretation of that reality (Hu, 2018). According to critical realism, human knowledge “*captures only a small part of a deeper and vaster reality*” (Fletcher, 2017, p.182), and enables knowledge to be gained in relation to theories which can facilitate becoming closer to reality as theories can help to identify causal mechanisms of phenomena (Fletcher, 2017). In accordance with Bhasker, Danermark and Price (2017), this requires consideration of both structure and agency, whereby observable human agency and unobservable social structure are equal parts of causal explanation. This recognises how individuals have agency in how they perceive and shape their world, rather than viewing the social world as static. As the study aimed to explore how recipients and providers of the DVA intervention interpreted the reality of that service, I adopted a critical realist position. In line with critical realist philosophy, the service was a real intervention with a reality. Critical realism acknowledges that perceptions of reality are influenced by individuals’ interpretation of this reality at an individual and social level. Thus, reality can be perceived in contrasting ways. Adopting this position was right for this study, in light of how I aimed to explore intervention recipients’ and providers’ views about an intervention. I approached this study by recognising that individuals’ perspectives of an intervention may contrast despite experiencing the same service (Walsh & Evans, 2014). Adopting a critical realist perspective was also right for this study given the exploratory nature of the study and the decision to undertake a qualitative approach (which is further discussed in Section 4.5) as qualitative methods “*are more capable of describing a social phenomenon and producing situated analytical explanations*” (Hu, 2018, p. 124). Being more aligned with critical realism shaped how I viewed the findings from the study. I viewed the findings as an interpretation influenced by how participants interpreted reality, in addition to the context and beliefs that I brought to the study.

4.4 Ethical framework of the study

4.4.1 A feminist ethic of care

I had not intended to root this study in feminist theory, particularly given my stronger realist position which had initially influenced my approach to doctoral research at the outset. However, I became increasingly aware that as I embarked upon and undertook this qualitative study, I was adopting principles associated with feminist research and a feminist ethics of care framework, influenced by the literature I was reading and through my conversations with other DVA researchers. It has been argued that feminist ethics of care provides a sophisticated framework for dealing with ethical dilemmas within qualitative research (Edwards & Mauthner, 2002; Roberts, 1981; Stanley & Wise, 1983). The framework encourages researchers to ground their decisions in the circumstances they face, whilst being mindful of the well-being of participants. This framework has been adopted in many child-centred research projects, to encourage flexible and reflexive consideration of ethical issues as they arise (Graham, Powell, & Taylor, 2015). In the research relationship between participant and researcher, this ethical approach emphasises the importance of cultivating trust, care, empathy and respect (Campbell, Sprague, Cottrill, & Sullivan, 2010).

4.4.2 A child-centred approach

Given that I wanted to prioritise the voice of the child in relation to children's experiences about the interventions, this study drew upon the substantial body of child-centred research methods literature (Alderson, 1995; Alderson & Morrow, 2011; Christensen & James, 2008; Christensen & Prout, 2002; Graham et al., 2015; Kellett, 2010; Kirk, 2007). Child-centred approaches, in common with those advocated by a feminist ethics of care framework, emphasise the importance of researchers being reflexive and attempting to minimise power-hierarchies between themselves and participants (Legard, Keegan, & Ward, 2003; Mason & Hood, 2011; Maynard, 1994). Such principles also represent good practice when researching with adult populations (Punch, 2002). I was particularly aware of the power inequalities implicit in researching with children. According to Kirk (2007) "*the unequal power relations that exist between children and adults [in wider society] are duplicated in the research process*" (p. 1252). Although the ethical considerations of the research participants will be discussed later in this chapter, it is worth noting at this point that combining the feminist ethics of care framework and child-centred approach enabled me to adopt both a robust and responsive ethical framework, appropriate to the research being undertaken.

4.4.3 Adopting both a feminist ethic of care and a child-centred approach

Adopting a feminist ethic of care and a child-centred approach was important to me in the context of DVA and the involvement of children as study participants. Both approaches were aligned as they are underpinned by the idea of reducing power inequalities between researcher and participants and privileging the ‘voice’ of participants, with participants having the right to both participation and protection. Whilst there was alignment between these approaches, I experienced a tension between them arising from participants’ rights to participate and to be protected. In practice, this arose from recruiting children through their mothers, a process which is further explained in Section 4.7. Whilst I wanted to provide opportunities for children to be involved in the research, I needed to gain parental consent to consult with the children as part of the University’s ethical approval process. These opportunities to invite children depended on mothers to initiate this invitation, which at times, I felt did not necessarily prioritise a child-centred approach. I felt that there were tensions in pursuing a feminist ethic of care so that mothers felt empowered to decide if, when and how they communicated this research opportunity with their child. Simultaneously, I wanted to ensure that every child had the opportunity to share their personal experiences. I tried to resolve this tension by communicating to mothers that children as well as adults have the rights to protection and participation and were experts of their own lives. I perceived that mothers’ own positive experience of participating in the research often encouraged them to initiate a conversation with their child about the research opportunity.

4.5 Methodology and methods

4.5.1 Qualitative inquiry

In order to pursue the aims of the study, and due to the limited research in this area, it was paramount that the voices of both children and adult participants were valued and heard, promoting a partnership approach through an interactive dialogue with participants (Berg, 1998; Mudaly & Goddard, 2009; Warr, 2004). Especially as the research aimed to involve children, qualitative inquiry can facilitate children sharing their definitions and interpretation of events, as they tell their personal accounts in their own voice (Mudaly & Goddard, 2009). In light of the limited yet growing body of qualitative DVA research with regard to interventions for children, I designed this qualitative study to be exploratory. Qualitative research emphasises process and meaning, capturing in-depth experiences in order to understand complex situations

(Reid, 1996), and emphasising the meaning and richness of qualitative data rather than its replication (Lombard, 2015).

4.5.2 Semi- structured interviews

Interviewing is the most commonly used qualitative method of data collection (King & Horrocks, 2010), focusing on participants' personal accounts to illuminate meaning (Legard et al., 2003). Interviews have increasingly been used to explore the experiences of children participating in DVA interventions (Callaghan & Alexander, 2015; Cater, 2014; Howarth et al., 2016). I decided to conduct semi-structured interviews with participants in order to facilitate a flexible approach to interviewing without being too rigid. The semi-structured approach enabled me to invite participants to discuss specific topics whilst not restricting them in the issues they chose to discuss. Furthermore, the semi-structured nature of the interviews provided some structure, which helped in facilitating cross-case comparability between participants' accounts (Bryman, 2016).

Prior to any data collection, I prepared an interview guide (see Appendix 7) which provided some topic areas that could be explored for each participant group (children, parents and intervention providers), such as the purpose of the intervention, the perceived impact of the intervention and how participants viewed it, and their personal experiences of being involved in the intervention. These initial interview guides were designed to invite participants to share some information about themselves, such as their hobbies and interests, to 'ease' them into the interview. Beginning the interview by asking broad questions that focused on the present aimed to encourage a non-threatening opening (Kirk, 2007). When closing the interviews, the final questions aimed to provide some focus for participants with regard to their current situations, helping participants to look ahead to what they hoped for in the future, with the aim that the interview would end on a positive note. In relation to the interviews with children, the flexible interview style facilitated the adoption of child-specific approaches which invited children to engage in other activities during the interviews, such as using crayons to draw or interacting with toys (Cappello, 2005; Doverborg & Pramling Samuelsson, 2003 as cited in Einarsdottir, Dockett, & Perry, 2009; Parkinson, 2001). Follow-up interviews with participants enabled opportunities for participants to further share and elaborate their experiences, and for me to present follow-up questions. I did not intend to restrict the interviews to only asking the specific questions that were included in the interview guides, nor rigidly adhering to the order in which the questions were asked. Rather, the

interview guides provided me with topic areas that could be explored and I encouraged participants to discuss issues that held particular interest to them.

Consistent with qualitative research principles, I viewed the interview guides as part of an iterative process which required me to be responsive over the course of data collection. Thus, the initial interview guides that I developed were not intended to be the only versions that I used. I used the initial interview guides flexibly and this was fundamental to being responsive and following-up new leads of enquiry with participants, and seeking clarification.

I developed the interview guides whilst I collected data and began analysing the interviews. Adjustments to the initial interview guides were made in light of interviewing the three distinct participant groups. As there were multiple voices in the study and the time points at which participants were interviewed varied, I was able to refine my questions over the course of the study. One example of this was how I asked intervention providers to share their experiences about how they viewed specific intervention activities, but the development of these questions had been informed through the interviews with the children when they shared their views of certain intervention activities. Another example was in relation to the parents' interviews, whereby my enquiry about parental engagement in the interventions arose from concerns about parental engagement expressed by providers. As a result I asked parents about the factors which affected their engagement in the intervention and in particular their views about the parent sessions. These conversations with parents then informed questions I followed up with intervention providers in subsequent interviews. Thus the questions were refined over time as data were generated and analysed.

4.5.2.1 Note taking

Taking notes during interviews served the purpose of recording helpful prompts in the context of the interview. If participants mentioned something in the interviews that I wanted to follow-up, I made brief notes in order to remind myself (Rubin & Rubin, 2005). Where possible, the notes also included observations about participants' body language and facial expressions, which I subsequently documented in interview transcripts to facilitate data analysis.

4.5.2.2 Recording the interviews

To record the interviews, I used a pocket-sized, electronic dictaphone, which was easily portable and posed minimal visual distraction. Although I ensured that the dictaphone was fully charged before each interview, I brought the dictaphone charger along to the interview in case the battery drained unexpectedly. The audio recording was

deleted from the dictaphone once the interview was fully transcribed. I presented participants with the dictaphone so they were aware of how I was recording the interview. Although one child was particularly excited that her interview would be recorded, another child showed some initial reluctance. However, this reluctance receded once I had assured her that it would only be myself who would listen to the recording, and that it would be deleted once the interview was transcribed.

4.6 Sampling

As qualitative inquiry usually focuses on capturing in-depth information from purposefully selected samples, the logic of sampling is not embedded in generating samples that are generalisable to the population at large (Patton, 2002). As this study was situated in context of an area of limited research, capturing a range of experiences and beliefs amongst participants was important. I adopted purposive sampling, a sampling technique widely used in qualitative research which involves identifying and selecting individuals or groups of individuals that are especially knowledgeable or experienced in relation to a phenomenon of interest (Cresswell & Plano Clark, 2011). Generic purposive sampling was undertaken whereby sampling enabled the selection of participants based on criteria central to the research questions of the study (Bryman, 2016).

4.6.1 Participant inclusion criteria

Participants were eligible to take part in the study based on whether they met certain criteria. Although English did not need to be their first language, participants were expected to converse fluently in English to participate in the in-depth interviews. Children were eligible to take part if they had attended any of the three interventions for children provided by the DVA organisation and again, irrespective of how many sessions they had attended, or whether they had ‘dropped out’ of the intervention. Parents whose child attended any of the three interventions were also invited to take part in the study; parents’ participation was not determined by how many sessions their child had attended, or the number of parent sessions that they attended. Importantly, it should be noted that in order to protect the safety of participants and myself, children or parents who were known as experiencing DVA at the time of recruitment or the intended interview time were not interviewed.

The intervention providers were eligible to take part if they had, in some capacity, experience of providing, developing, delivering, and/or coordinating any of the

three DVA interventions for children provided by the DVA organisation. There was no exclusion criterion regarding the ‘amount’ of experience they had in their role.

4.7 Study recruitment

My existing contact with the DVA organisation gained through Study 1 facilitated the recruitment process for Study 2, with regards to identifying and gaining access to key individuals who could be invited to participate. The individuals I had identified were children who attended one of the three interventions, their parents (non-perpetrator), and individuals involved in the provision, design, delivery and/or coordination of the interventions. Ideally, children and parents associated with different cohorts of the interventions would have been interviewed. However, the extent to which this was possible was limited by the unpredictable nature of when interventions were to be delivered to different cohorts, challenges in accessing participants within the limited timeframe of my PhD, and safely accessing participants through gatekeepers. Opportunities for recruiting participants and conducting follow-up interviews were also limited in light of participants’ availability, participants changing their mind about participation, and being able to successfully contact participants.

As the sample comprised those who were eligible and interested in taking part, this had implications regarding which children and parents participated; those children who had dropped out of the interventions, and consequently their parents, were not interviewed. The self-selecting nature of the sample meant that this had implications for the data collected (Bryman, 2016). Given the challenges of recruiting participants and the lack of research in this area, it was felt that, despite the small pool from which a sample could be drawn, the exploratory nature of the research made the study worthwhile.

4.7.1 Recruiting children and parents

As children and parents who have experienced DVA are a relatively hidden, and hard-to-reach population (Bunston et al., 2015; Stanley, 2011), and as children have largely been overlooked in DVA related research, recruiting children and parents through the DVA organisation was a viable way to gain access to them. The DVA organisation was likely to be aware of changes in family circumstances, such as family members continuing to experience DVA, which would exclude them from the study. Having an awareness from the DVA organisation regarding which families were ‘safe’ to contact was important for ensuring the protection of participants. However, it could not be guaranteed as to whether the organisation was always fully aware of the most

current situation of the family particularly as interviews took place over the course of one year. In addition to receiving an indication from the DVA organisation as to whether it was 'safe' for me to contact families, I also asked parents to let me know prior to an interview whether or not it was still 'safe' for themselves and/or their child to be interviewed, in light of their family circumstances. While using the DVA organisation as gatekeepers could have unduly influenced the sample, this needed to be balanced against the difficulties of otherwise accessing this group (Miller & Bell, 2002). I approached the last three cohorts of the seven intervention cohorts involved in Study 1, which meant that one cohort per intervention was invited to take part in the qualitative study. These cohorts were more accessible for me to contact compared with historical intervention cohorts.

Parents were invited to participate in the interviews before children were invited, and they too acted as gatekeepers for the children. It was important for me to gain trust with parents first, particularly given the sensitive nature of the interventions. As I had already approached parents in relation to Study 1, I distributed recruitment leaflets for Study 2 to parents at the intervention. These leaflets briefly outlined the opportunity for them to take part in an interview (Appendix 8). If parents were interested, they were invited to either to contact me about Study 2 directly through the details provided in the leaflet, or to provide me with their contact details and specify a suitable time for me to contact them.

The first set of interviews with parents took place at different points during the course of the interventions, according to parents' availability. In total, six parents participated in the interviews. This comprised, three parents of three children who participated Intervention A and three parents of three children who participated Intervention B. No children or parents took part in relation to Intervention C.

In the event, I was only able to conduct follow-up interviews with the three parents whose children attended Intervention A, and this enabled them to share their experiences post-intervention. I also used these follow-up interviews as an opportunity to enquire about whether mothers would inform their child about the invitation to participate and ask their child if they wanted to have a 'pre-research conversation' with me at a later date to find out further information. All three mothers were happy for me to do this. The purpose of the pre-research conversation was to personally invite the children to participate and to provide the child with the 'space' where they could consider their own participation. This also served the purpose of enabling me to get to know the child and build rapport with them. Through the pre-research conversation I

learned about one child's particular enjoyment of drawing. I integrated this into the subsequent interviews with her by inviting her to draw using resources that I had brought, and this facilitated her engagement during the interview. During a pre-research conversation with another child, the child voluntarily showed me a puppet that she received at the end of the intervention she attended. As this puppet was associated with the intervention, I invited the 'puppet' to accompany the child in the interview if the child wanted, which also provided an opportunity to discuss the significance of the puppet, which will be further discussed in Chapter 8. All three children expressed positive interest in participating in the interviews.

It is recognised that my decision to recruit the children through their mothers may have encouraged a 'double' power hierarchy whereby there was pressure from their mothers and myself to participate. It was important for me to minimise this where possible. Whilst recruiting children directly may have minimised parental pressure for them to participate, I decided against this option for two reasons. Firstly, given the sensitive nature of the interventions and potential family history of DVA, parents may have wanted to protect their child from emotional harm, in the same way that the DVA organisation may have screened out families who were experiencing many problems. Mullender et al. (2002) have argued that this is an important consideration for parents who are victim/survivors of DVA and who may have recently been freed from the control and power of the perpetrator. Thus, it was important that I did not undermine a parent's responsibility for their child. Secondly, if I had directly approached the children, this would not have necessarily guaranteed their openness, but having reassurance from parents may have facilitated this (Lewis, 2009).

One particular challenge I experienced was coordinating interviews that took place in the homes of participants. Despite expressing an interest in participation, there were often instances when parents needed to rearrange their or their child's interviews at short notice. There were also occasions when there was less time than anticipated for the interview to take place. It was paramount that I remained flexible in my availability and tailored my approach to the circumstances and complexities of the lives of participants. In practice, this meant that there were inconsistencies in the time-points at which interviews were conducted with participants. Often this resulted in conducting more follow-up interviews than anticipated and the time points between interviews varying.

4.7.2 Recruiting intervention providers

I recruited the intervention providers through an individual employed by the DVA organisation, who enabled me to identify the staff to be approached. Depending on

the availability of intervention providers, I invited them to participate via email, telephone or in person.

4.8 Sample composition

In order to ensure anonymity and to protect the identity of participants, particularly due to the small sample size, I present limited demographic details about the participants. To provide further context of the study, Table 4.1 identifies the number of individuals who were potentially eligible to participate in the qualitative interviews, how many were approached per intervention and how many were actually interviewed. It should be noted that some intervention providers were involved in providing more than one of the three interventions.

Table 4.1: Composition of individuals who were eligible, invited and participated in Study 2

Intervention	Number of potentially eligible participants	Number of individuals invited	Number of participants in the study
Intervention A	14 children	3 children	3 children
	14 parents	6 parents	3 parents
	11 providers	11 providers	9 providers
Intervention B	14 children	0 children	0 children
	14 parents	7 parents	3 parents
	6 providers	6 providers	6 providers
Intervention C	5 children	0 children	0 children
	5 parents	5 parents	0 parents
	6 providers	6 providers	3 providers

In total, the sample in this study who participated comprised: three children (three females) aged between eight and ten years; six parents (five mothers and one father); and 12 intervention providers (ten female and two male). Whilst all the parents whose children attended Intervention A were victim/survivors of DVA, two out of three parents whose children attended Intervention B were victim/survivors of DVA. All the interviews were conducted between 2015 and 2016. The intervention providers

comprised individuals who played a role in the provision, delivery, coordination and/or development any of the three interventions. Whilst this collective group of individuals will be referred to as ‘intervention providers’, there may be instances in this thesis where their specific role, such as ‘facilitator’, is used specifically. This group of individuals included the coordinator of the interventions, the CEO of the DVA organisation, a manager of a partner organisation and the author of Interventions B and C. As highlighted in Chapter 3, some of the intervention providers were staff members employed by the DVA organisation, whilst others were employed externally. Facilitators had a range of educational and professional backgrounds. Those facilitators not employed by the DVA organisation worked as family or victim/survivor support workers.

The gender bias associated with this sample is recognised. However, this was not surprising given the gendered nature of DVA, and the fact that the sample of children only derived from one cohort of Intervention A which was predominantly female.

Overall, 35 separate interviews were conducted. As highlighted in Table 4.2, there were three occasions where there were ‘joint’ interviews, in which two children and two mothers were interviewed at the same time. In total, the duration of the interviews ranged from 20 minutes to two hours and 45 minutes and the average interview length was one hour and one minute. The parents were first interviewed whilst their child participated in an intervention session at the time and location in which the interventions took place. Follow-up interviews with parents and subsequent interviews with children, took place in their homes, a preference which children and parents specified. Interviews with intervention providers were undertaken at the premises of the DVA organisation or at a place of work. Tables 4.2, 4.3 and 4.4 provide details regarding the overall composition of participants and how many interviews they participated in. Tables 4.2 and 4.3 specify when children and parents were interviewed in relation to the timing of the intervention. As mentioned in Section 4.7.1, these interview time-points varied across participants due to the challenges of arranging interviews. For ease of reference, Appendix 9 provides a glossary of participants.

Table 4.2: Composition of child participants

Participant	Intervention	Number of interviews	Timing of interview
Kwaii-Chan	Intervention A	3	Interview 1: 10 months post-intervention* Follow-up 1: 11 months post-intervention* Follow-up 2: 12 months post-intervention
Penny	Intervention A	2	Interview 1: 10 months post-intervention Follow-up 1: 11 months post-intervention*
Cinderella	Intervention A	2	Interview 1: 11 months post-intervention Follow-up 1: 12 months post-intervention

**Child-parent joint interview*

Table 4.3: Composition of parent participants

Participant	Intervention	Number of interviews	Timing of interview
Jackie (mother)	Intervention A	4	Interview 1: Week 6 of intervention Follow-up 1: 7 months post-intervention Follow-up 2: 10 months post-intervention* Follow-up 3: 11 months post-intervention*
Zoe (mother)	Intervention A	4	Interview 1: Week 5 of intervention Follow-up 1: 6 months post-intervention Follow-up 2: 8 months post-intervention Follow-up 3: 11 months post-intervention*

Naomi (mother)	Intervention A	3	Interview 1: Week 5 of intervention Follow-up 1: 7 months post-intervention Follow-up 2: 8 months post-intervention
Fiona (mother)	Intervention B	1	Interview 1: Week 6 of intervention
Elaine(mother)	Intervention B	1	Interview 1: Week 6 of intervention
Steve (father)	Intervention B	1	Interview 1: 2 weeks post-intervention

**Child-parent joint interview*

Table 4.4: Composition of intervention provider participants

Participant	Role	Intervention	Internal or external to DVA organisation	Number of interviews
Helen	Facilitator	Intervention A	External	2
Vicky	Facilitator	Intervention A	External	1
Sue	Facilitator	Intervention A	External	2
Sandra	Facilitator	Intervention A	External	1
Emma	Facilitator	Intervention A	Internal	1
Zara	Facilitator	Interventions A and B	External	1
Mike	Facilitator	Intervention B	Internal	1
Joe	Facilitator	Intervention B	External	1
Eleanor	Facilitator and Interventions' Coordinator	All Interventions	External	3
Chrissie	Intervention Author	Interventions B and C	External	2
Simone	CEO of DVA organisation	All Interventions	Internal	1

4.9 Ethical considerations for research participants

Ethical approval for this study was given by the University of Liverpool Research Ethics Committee (see Appendix 10 for confirmation of ethical approval). The following section discusses in further detail the ethical considerations given to the participants of this study.

4.9.1 Gaining consent

All participants were provided with information sheets and were asked to provide written informed consent (see Appendix 11 and 12). Participants were provided with information sheets well before their participation, enabling them to ask questions or raise concerns about their involvement in the research. I discussed with participants the purpose of the study and they were invited to participate in the study. All participants were informed that they were under no obligation to answer all of the questions asked in the interview, and that they could stop the interview at any point without having to provide a reason. Explicit verbal consent was requested from all participants on the occasion of each follow-up interview, as it was possible that their decision to participate may have changed over time. All consent forms were stored in a locked cabinet.

4.9.1.1 Consent for children's participation

Whether or not children and young people under 18 years should provide consent or assent is a highly contested issue (Graham et al., 2015). For children's participation in the study, I decided to obtain informed consent from both child and parent. It was important to provide children with clear information about the purpose and nature of the study, so that they were fully informed about the study and understood that they did not have to participate (Edwards & Alldred, 1999; MacNaughton & Smith, 2005). Upon reflection, the information sheet provided to the children could have adopted a more child-centred approach, to present the information in a manner comprehensible and accessible to the children's level of development (Berglund, 1995; Edwards & Alldred, 1999; Grinnell, 1993; Mudaly & Goddard, 2009), and could have included visual aids to facilitate the communication of key points (Alderson & Morrow, 2004).

As was the case with the adult participants, children were not rushed to consider their participation in the research, as advocated by Alderson (1995). The question of whether parental gate-keeping can be bypassed to ensure children's rights to

participation has also been raised (Carroll-Lind, Chapman, Gregory, & Maxwell, 2006; Thomas & O’Kane, 1998). However, given children’s rights to protection and participation in accordance with the UNCRC (1989), it was felt that bypassing parental gate-keeping would be inappropriate as upholding these rights during and after the research process was essential (Mudaly & Goddard, 2009). It was also important for children to be aware that parental consent had been given to help the children feel at ease with the opportunity of sharing their experience of the intervention and potentially their experiences of DVA, which they may have been used to keeping secret from outsiders (Cater & Øverlien, 2014). In DVA research, it is often appropriate to only seek the consent from the victim/survivor parent (Eriksson & Näsman, 2012; Mudaly & Goddard, 2009; Øverlien & Hydén, 2009). However, deciding not to obtain consent from the DVA perpetrators may have put the children at risk if the perpetrators found out about their participation in the intervention and had not previously been aware of it, as well as children’s involvement in the research (Cater & Øverlien, 2014). By communicating with the DVA organisation and non-offending parent, I gained awareness about the nature of the contact between the perpetrator and the child and family. In the cases of the three children who participated, the perpetrator had either been incarcerated, moved to another location and contact no longer continued, or the perpetrator had limited supervised contact with the child and was aware of their child’s participation in the intervention. In light of this, gaining consent from the child and from only the parent who was the victim/survivor was deemed appropriate for a child’s participation in the study.

4.9.2 Confidentiality and anonymity

I informed all participants from the outset that interviews would remain confidential, with the exception that confidentiality would be breached if disclosures of safeguarding concerns or criminal activity were made. All participants were informed that if I had concerns about the safety and welfare of a child then I would be obliged to contact a professional who could assist through the DVA organisation. Thus, any possible breach of confidentiality would be to protect the child from harm (Cater & Øverlien, 2014). Explaining this prior to gaining consent, as well as when consent was given, was important so that all participants were reminded of the potential implications arising from the information they disclosed.

All participants were reassured that they would not be identifiable from the research findings and that they could either choose a pseudonym for me to use when writing up the findings, or, if they preferred, I could create a pseudonym for them. The

selection of pseudonyms by the children appeared to be influenced by contemporary popular culture.

I informed participants that their data would be used without compromising their rights to confidentiality, privacy and anonymity (Williamson, Goodenough, Kent, & Ashcroft, 2005). The children were given the choice of being interviewed with or without their parent being present. It was explained that if they wanted their parent to be present, then their parent would be aware of what they shared in the interview. Two children, Kwaii-Chan and Penny, said they were happy for their mothers to sit in the same room as them during the interview and also specified that they were happy for their mothers to 'join in' with the interview. This made it a 'joint' interview that was led by the child, who could decide at any point that they would prefer to have the interview without their mother's contribution and/or presence. It has been observed that there can be divergent views about DVA amongst family members (Sands & Roer-Strier, 2006). Thus, due to the 'joint' nature of the interviews, it was important to reassure all participants that having different viewpoints did not invalidate their experiences of the interventions or DVA.

4.9.3 Potential harm and conduct of research

Although different philosophical positions underpin qualitative research, it remains paramount to balance the interests of the research with the responsibility for participants' welfare (Gatrell, 2009). A key concern for researchers in sensitive areas of research, is the extent to which participants can become upset or distressed by participating (Campbell et al., 2011). This was particularly important to consider in light of the reasons for which children were eligible to attend an intervention, the content of the interventions, children and parents' experiences of DVA, intervention providers' daily work with violence-based cases and the possibility that intervention providers were victim/survivors of DVA. It has been argued that researchers should be ethically responsible for the lives and well-being of participants in carrying out research with 'vulnerable' individuals and ensure that participants' involvement in research does not make them 'more' vulnerable (Flaskerud & Winslow, 1998; Lee, 1993). The importance of ensuring that the research process did not exploit and 'use' participants for research nor traumatise participants (Hollway & Jefferson, 2000; Rubin & Rubin, 2005) was underlined by one mother, who reported having to repeatedly relate her family's experience of DVA to the different social workers who worked with her family. In addition, one child talked about wanting to 'move on' from her experiences of DVA.

Whilst wanting to empower participants, I took the view that the welfare of the participants was paramount. Therefore, if participants appeared uncomfortable or became upset during the interview, they were offered a break or the opportunity to stop or withdraw from the interview. In order to respond to any distress experienced as a result of participating in the interviews, children and parents were encouraged afterwards to seek further support from the DVA organisation, and intervention providers were encouraged to seek support from a supervisor or colleague. It is important to highlight that some degree of distress is not unusual because involvement in the research would have reminded participants of their personal circumstances, or the experiences of others (Campbell et al., 2011). Nevertheless, it has been observed that most participants do not describe their involvement in sensitive research as being unexpectedly upsetting (Newman & Kaloupek, 2004 in Campbell et al., 2011). Downes et al. (2014) have noted that in instances where women have been asked to reflect on their participation in DVA research, they tended to regard the research process positively, and reported being able to ‘tell their story’ through the interview process.

As parents were first interviewed whilst their child was attending one of the interventions, parents were reassured that their decision to participate and what they shared during the interview would not affect the quality of the service received by their child. Furthermore, intervention providers were informed that their decision to participate or not, would not be used to evaluate their performance or reputation, and what they shared in the interview would not be presented in such a way that it negatively affected their professional reputation. After each interview, all participants were debriefed and were invited to share their thoughts about the interview. It cannot be known for certain how participants experienced the research process, but from the verbal feedback received from children and adults, and through children’s gifts of drawings to me, it seemed to be positive.

4.9.4 Benefits of research participation

It was important to set out the expectations of participants’ involvement in the study. I explained to children and parents that this study would not directly benefit their immediate situation, but that it might help other children and parents in the future (Cater & Øverlien, 2014). Two children particularly expressed their desire for their participation to ‘make a difference’. As the DVA organisation was usually unaware of a family’s circumstances one year after an intervention, children and parents were informed that they should initiate contact with me in order to discuss the findings of the research.

Intervention providers were informed that the findings from the study would neither immediately nor directly change their work situation in relation to the interventions. I informed them that they would be invited to attend a presentation of the research findings and that a practitioner report highlighting the key findings would be made available to them. Encouragingly, providers reported that their participation had encouraged them to reflect critically on their own professional experiences and practice.

4.9.5 Acknowledgement of participation

All participants were thanked for their participation in the research. They have been anonymously acknowledged in the dissemination of this research, and will be in the future. As intervention providers were interviewed during their working day as part of their involvement in the interventions, and as parents had not taken time off work due to their flexible working hours or being unemployed, this meant that they were not reimbursed for the time taken up by the interviews. However, they were informed that travel expenses for their participation in the study would be reimbursed if needed.

There is considerable debate regarding the payment of children and young people for their participation in research (Kellett & Ding, 2004) and what constitutes appropriate payment (Alderson & Morrow, 2011; Gallagher, 2009). I decided to give the three children a £10 shopping voucher to thank them for their time and effort in participating in the research (Fargas-Malet, McSherry, Larkin, & Robinson, 2010; Hill, 2005; Laws & Mann, 2004). In order to minimise any pressure on the child to participate, when I informed parents about the research opportunity for their child I did not mention that they would receive the voucher. It was only when I visited the child to explain the research that they were informed about receiving the voucher, and that they would still receive it even if they withdrew from the interview. Although I interviewed with the children over separate visits, the children received their voucher after the first interview. In hindsight, vouchers could have also been given to parents and intervention providers to thank them for their time.

4.9.6 Managing researcher and participant positionality

Recognising researcher and participant positionality is important in qualitative research (Acker, 2000; Cook & Fonow, 1990; Ganga & Scott, 2006; Harding, 1992; Reinharz & Davidman, 1992; Stanley & Wise, 1983). The following section discusses important considerations of this research study in relation to positionality, in light of the insider-outsider status and managing power-hierarchies.

Qualitative researchers have extensively discussed the benefits and drawbacks of researchers being ‘insiders’ or ‘outsiders’ to the community they study (Kerstetter,

2012). The notion of the insider-outsider status or “*inquiry from the inside and inquiry from the outside*” (Evered & Louis, 1981 cited in Louis & Bartunek, 1992, p.101) captures critical characteristics of the stance of a researcher, regarding the extent to which the researcher is located either within or outside the group being researched. This position is based on the researcher’s common lived experience or status, such as age, class, gender and ethnicity as a member of that group (Gair, 2012; Ganga & Scott, 2006). The outsider stance has previously been considered preferable as it guards against over-identification, although more recently it has been argued that the involvement of a researcher with insider insight or ‘common wounds’ may be more desirable (Gair, 2012). A number of benefits to being an ‘insider’ researcher have been recognised, including the researcher using their shared experiences to more easily engage with participants and show empathy, with the view that this can facilitate the recruitment of participants (Dwyer & Buckle, 2009). However, it has been acknowledged that the ‘insider’ researcher may face challenges in separating their personal experiences from those of research participants (Kanuha, 2000). In contrast, ‘outsider’ researchers have reported finding it easier to emotionally distance themselves from the experience in discussion, although they may have difficulties in accessing potential participants (Chawla-Duggan, 2007; Gasman & Payton-Stewart, 2006).

The notion of the insider-outsider status has been critiqued as presenting an overly simplistic dichotomy (Breen, 2007) as this status may be more fluid than fixed, as an individual may not ‘fit’ into one position precisely (Boulton, 2000; Dwyer & Buckle, 2009; Haviland, Johnson, Orr, & Lienert, 2005; McKinley Brayboy & Deyhle, 2000; Tuhiwai-Smith, 1999). For example, a researcher may share a similar lived experience as those participating in their research, but they may find it difficult to have empathy with them or automatically share critical awareness and understanding, particularly if the researcher has different experiences regarding the same issue. Whilst there may be an illusion of assumed insider similarities, insiders may not all hold the same view or have the same shared experiences (Kelly, Burton, & Regan, 1994; Letherby & Zdrodowski, 1995). Nevertheless, the ways in which these ‘insider/outside’ tensions can be creatively responded to is important for researchers to consider (Acker, 2000).

Throughout the research I identified myself as being positioned more closely as an ‘outsider’: I was a highly qualified university graduate and postgraduate researcher, adult, white, ‘middle class’, with no personal experience of DVA. Unlike the children, I had not attended a DVA related intervention. Therefore, I positioned them as experts in their experiences and the children appeared to enjoy ‘educating’ me about the

intervention they attended. In relation to the parents, I did not share experiences of being a parent myself. The majority of parents had not been university educated, and unlike myself, most of them had experienced DVA. However, one mother reported that she was well disposed towards me because I was neither a social worker nor another professional working in the arena of DVA with whom she had previous negative experiences of feelings patronised and judged. Unlike the intervention providers, I did not have any first-hand experience of delivering, coordinating or developing an intervention. As I was a doctoral researcher based at a university, intervention providers may have perceived me to be testing them in some way and judging their expertise. In light of this, I was especially mindful of how I constructed questions so as not to assess their competence or come across as judgmental.

My awareness of the potential power-hierarchies and their effects on the research, informed my attempts to minimise them. As recommended by Eriksson and Näsman (2012) who conducted interviews with children who had experienced DVA, I used humour to highlight mistakes or errors I made, while, for instance, interviewing. In terms of my physical position while interviewing with the children, if a child chose to sit on the floor, I sat there with them so that we were positioned at the same physical level (Mason & Hood, 2011; Shaw, Brady, & Davey, 2011). Rather than wearing clothes that might emphasise my ‘professional’ role, I chose to wear clothes that appeared less formal whenever I met participants. I also wanted to ensure that all participants understood that I was interested in their views and that there were no ‘right’ or ‘wrong’ answers to give during the interview. The feminist ethic of care framework and child-centred approaches adopted in this study appeared to facilitate the establishment of positive relationships with participants.

4.10 Ethical considerations for the researcher

Whilst researchers may be well-versed in explaining ethical considerations in relation to participants, it has been argued that the safety and welfare of researchers is often “*thought through in a cursory manner or in an ad hoc contingent fashion once in the field*” (Lee-Treweek & Linkogle, 2000, p.1). In research concerning DVA there is often concern about the heightened safety risks for researchers who may conduct research at a DVA organisation or in family homes to which a perpetrator has access (Houghton, 2008; Morris et al., 2012). As highlighted in Section 4.7.1, both the DVA organisation and parents were involved in communicating to me whether it was ‘safe’ for interviews to go ahead with parents and children. For all interviews, I informed my

doctoral supervisor of the time and location of the interview, and I contacted her when I arrived at the interview location and when I had safely left.

Another important issue to consider in the context of this study was my emotional wellbeing, particularly when participants discussed the interventions with reference to personal experience or case study examples. Ellsberg and Heise (2002) have argued that listening to women's stories and experiences of DVA can be distressing for researchers, which may result in the researcher finding it difficult to conduct the research interviews. Establishing support and supervision systems have been acknowledged as paramount in conducting sensitive qualitative research (Liamputtong, 2007). I utilised formal support networks such as supervisors and colleagues who provided the opportunity for me to process the emotional impact of the research, whilst ensuring that the anonymity and privacy of participants was respected (Coles & Mudaly, 2010).

In light of the sensitive nature of the interviews, and the concentration needed to interview participants, it was important to leave enough space between interviews (Campbell, 2002; Dunn, 1991; Gerrish, 1991; Maslach, 1982). There were some interviews where I was particularly aware of experiencing emotional burnout (Figley, 1995), for example, when one parent initiated a conversation which detailed her personal experiences of DVA for an extended period of time during the interview. In another instance, remaining patient and enthusiastic with a very distracted child resulted in employing multiple techniques for engaging and interacting with the child, which at times I found extremely draining.

In response to the potential impact that the interviews may have had, I ensured that only one interview was conducted per day and I aimed to have at least a couple of days 'space' between interviews. In practice, the availability of participants and the varied geographical locations of where interviews took place meant that interview times were naturally dispersed. This provided me with the time to reflect upon each interview and undertake analysis. The spacing between interviews also facilitated opportunities for supervision sessions with one of my doctoral supervisors. In these sessions we discussed the challenges of the interviews, in addition to identifying which questions could be followed-up in subsequent interviews. Further consideration is given to the emotional impacts associated with this research study in Section 4.15, in light of my reflections post-data collection.

4.11 Interview transcription

This section discusses how the interviews were transcribed. All the interviews were transcribed verbatim at the earliest opportunity. Whilst I viewed the transcripts as an account of the interviews, a co-production between myself and the research participants, I also regarded them as an artefact which I had an active role in producing (Alldred & Gillies, 2002), because I made interpretive decisions about what was transcribed and how the material was presented (Bucholtz, 1999). Situated in a critical realist ontology and subjectivist epistemology, I was aware that I was not entirely neutral in the analysis and presentation of data.

When transcribing, I tried to use participants' exact words to reflect the dialogue between the participant and myself. As Charmaz (2014) has argued, nuances of participants' language can provide some insight into their meaning. Therefore, when transcribing, I utilised both the audio recordings and the field notes as a prompt, noting non-verbal cues where possible, such as, pauses, sighs, physical gestures, and laughter. Across all transcripts, I adopted consistent transcription practices (McLellan, MacQueen, & Neidig, 2003).

It has been suggested that recorded interviews should be listened to at least twice when transcribing them (McNulty, 2012). The first 'hearing' provides an overview of the interview, with regard to the dynamics, its tone and mood. The second 'hearing' provides an opportunity for the data to be scrutinised in more detail, and for transcripts to be checked for 'accuracy'. Poland (1995) proposed that 'mistakes' in transcription could be the result of a number of factors such as, fatigue, mishearing and being careless. Thus, I transcribed the interviews in small sections and I listened to the audio-recordings together with the transcripts so that I could read the transcripts more contextually (McLellan et al., 2003). Although the process of interview transcription was time-consuming, it was invaluable. I became quickly immersed in the data, which encouraged me to begin comparing participants' narratives from an early stage. All transcripts were stored securely on an encrypted device and printed versions of transcripts were secured in a locked cabinet. Any information which may have identified participants were removed from the transcripts.

4.12 Data analysis

Thematic analysis is a widely-used qualitative analytic method. Braun and Clarke (2006) have provided clear guidelines for its use as a standalone method, rather than as a generic tool used within qualitative analysis (Boyatzis, 1998). Thematic

analysis is flexible because it is not exclusively connected to one particular theoretical framework (Braun & Clarke, 2006) and can be conducted in a theoretically driven (deductive) or in a data-driven (inductive) manner, capturing both explicit and underlying meaning. One of the advantages of using thematic analysis is that it can be also used flexibly across research questions, sample sizes and methods of data collection (Clarke & Braun, 2017). In light of this, adopting Braun and Clarke's (2006) theoretically flexible approach to thematic analysis complemented the ontological and epistemological position of my study, in that analysis was theoretically underpinned by critical realism (Willig, 1999), affirming the existence of reality whilst recognising that *"its representations are characterized and mediated by culture, language, and political interests rooted in factors such as race, gender, or social class"* (Ussher, 1999, p. 45). Therefore, the views of participants were interpreted as depicting the reality of their experiences, without viewing them as independent of the context (historical, cultural, political, or social) in which they were situated. The choice to undertake a qualitative study arose from Study 1 and was influenced by prior observations in the literature concerning interventions for children who had experienced DVA. Thus, I came to the analysis with some pre-existing knowledge. However, due to the limited research in this area, most of the analysis was carried out inductively, especially as the depth of the information in the interviews challenged my ideas.

I adopted Braun and Clarke's (2006) definition of a 'theme', whereby a theme *"captures something important about the data in relation to the research question and represents some level of patterned response or meaning within the data set"* (p.82). Braun and Clarke described six phases of thematic analysis which involved familiarisation with the data, generating initial codes, searching for and reviewing themes, defining and naming themes, and producing the report. I now discuss what was done practically in this study in relation to these phases and it should be noted that these phases were implemented iteratively rather than adhering to a rigid and linear procedure.

As discussed in Section 4.11, I read and reread each interview transcript, immersing myself in the data and becoming very familiar with it. I started to highlight material that was relevant to the research questions, making comments about anything that stood out. I stayed close to the data and created a large array of codes. Coding involves organising units (words, sentences or paragraphs) of raw data into conceptual groupings, with codes being the tags or labels for assigning meaning (Miles & Huberman, 1994). Although coding was largely completed alone, a preliminary coding process was undertaken alongside one of my supervisors. Once the data had been

initially coded, I engaged in a sorting process, collating linked codes in tentative groupings at the broader level of themes. I sorted and re-sorted these codes into groups. Particularly during the early stages, this sorting process was facilitated by using post-it notes (see Appendix 13 for examples), to explore how the concepts hung together, and noting relationships between data. Data analysis was an iterative process, and I developed codes from simultaneous data generation and analysis.

Reviewing the themes, defining and naming themes and producing the report enabled me to establish themes which were coherent and distinct. These phases involved some prospective themes merging or expanding to include several components, whilst others were discarded. During the process of preliminary writing it became apparent that some themes were related or were too complex, and I was able to make alterations to the theme structure accordingly. In addition, the naming and defining took place in conjunction with the report drafting as I worked to describe the essence of each theme, explaining what it was, and what it was not. The results chapters for this qualitative study emerged from my initial writing and include vivid and compelling quotes to illustrate the points made (Bhaskar, 1998).

From these phases, my analysis moved from being descriptive to being interpretative, thus going beyond the surface level of the data to articulate meanings, implications and relevance of context (Braun & Clarke, 2006). After writing the initial draft of the findings chapters, I gave each theme to one of my supervisors in order to gain their perspective regarding the verification of the themes and the relationships between them. Presented in this thesis are six themes that I developed, and within these themes are subthemes, which provide “*structure to a particularly large and complex theme*” and indicate “*the hierarchy of meaning within the data.*” (Braun & Clarke 2006, p.92). The six main themes and their subthemes were as follows:

- **Theme 1: Divergent perceptions about an intervention’s purpose**
 - Subtheme 1: Children acquiring clarity
 - Subtheme 2: An intervention to support a child with difficulties
 - Subtheme 3: A solution
 - Subtheme 4: Preventing the ‘cycle of abuse’
- **Theme 2: The timing of an intervention**
 - Subtheme 1: Sooner rather than later
 - Subtheme 2: Children’s readiness to engage

- Subtheme 3: Parent's readiness to engage
- **Theme 3: The appropriate length of an intervention**
 - Subtheme 1: Prolonging intervention experiences
 - Subtheme 2: Prolonging the durability of intervention outcomes
- **Theme 4: The significance of who delivers an intervention**
 - Subtheme 1: Facilitators' characteristics
 - Subtheme 2: Experience of working with children
- **Theme 5: Barriers to evaluating interventions**
 - Subtheme 1: Limited engagement with intervention evaluations
 - Subtheme 2: Using the 'wrong' tools
 - Subtheme 3: Unmeasured outcomes
 - Subtheme 4: Accounting for intervention adaptability
 - Subtheme 5: Practical constraints of intervention evaluation
 - Subtheme 6: Barriers to joint-working
- **Theme 6: The contribution of qualitative methods in examining intervention outcomes**
 - Subtheme 1: Prioritising the voice of the child
 - Subtheme 2: Situating outcomes in context
 - Subtheme 3: Identifying unanticipated intervention outcomes

4.13 Presentation of qualitative themes

Chapters 5, 6, 7 and 8 will present the themes as I understand their relationship to the aims of Study 2. I felt it was important to distinguish between themes which represented common experiences within my sample and those which reflected perhaps more divergent experiences. With this in mind, and in line with the presentation of data by other qualitative researchers, I use terminology such as: some, a few, the majority, and all (Braun & Clarke, 2006).

Although the use of quotations is standard practice in the writing-up of qualitative research, it is not without issues which need consideration (Corden & Sainsbury, 2006). In this study, quotations were selected on the basis that they were a good exemplar relating to a particular theme or subtheme, illustrating the basis from

which I made my interpretations and conclusions. Quotations also enable the reader to make their own judgements about my analysis (Corden & Sainsbury, 2006). In instances where quotes have been shortened to remove identifiable information or for brevity, the omitted text is marked with ‘...’ and explanatory text is presented in brackets. As presenting the themes in a theme-by-theme manner may be challenging for the reader to understand how individual accounts are shaped, where appropriate and without comprising the identity of participants, certain contextual details are provided alongside the quotes (King & Horrocks, 2010).

4.14 Quality assurance

The contribution of qualitative research is increasingly recognised as invaluable for informing health and intervention research, and it is important that practitioners and policy-makers are confident about the quality of qualitative work (Dixon-Woods, Shaw, Agarwal, & Smith 2004). As this study was designed to be qualitative, it was fundamental that I considered how quality assurance would be addressed throughout the research process. However, there are a range of perspectives on what constitutes good quality qualitative research. In light of the plurality of qualitative methodologies, Dixon-Woods et al. (2004) argue that qualitative research should not be viewed as a unified approach to research. There are long-standing debates regarding how quality should be defined in qualitative research, especially when there is a *“lack of clear, structured guidance based on the intrinsic principles of qualitative research”* (Reynolds et al., 2011, p. 8). However, drawing upon fundamental principles which characterise qualitative research can provide an approach that facilitates quality assurance, in such a way that is consistent with the distinct values of qualitative research, and take into account a range of qualitative methodologies (Reynolds et al., 2011). There were a number of ways that I sought to address quality assurance in relation to the study design, methods, data collection, data analysis and write-up, and in light of the relevant literature. These were as follows: engaging in reflexivity, attending regular supervision meetings, presenting my findings to participants, DVA researchers and practitioners, seeking respondent validation, ensuring transparent and clear reporting of the study, and keeping an audit trail throughout the study. The following section discusses each of these.

Reflexivity has gained a vital role in qualitative research and is viewed as a fundamental practice in qualitative research (Hsiung, 2008). Reflexivity is the process of critical reflection undertaken throughout the research process (Charmaz, 2006),

involving researchers critically evaluating their own position as an enquirer and their emotional responses to participants' accounts as they interpret them (Davis, Watson, & Cunningham-Burley, 2000; Emond, 2005; Mauthner & Doucet, 2003). Engaging in reflexivity can make research findings more credible by the researcher engaging in self-critical appraisal and self-awareness, making explicit and transparent the researcher's contribution to the interpretive process (Liamputtong, 2009). Charmaz has proposed that researchers are obligated to be reflexive about "*what we bring to the scene, what we see and how we see it*" (2014, p.27). Furthermore, Charmaz (2014) has argued that "*We are not scientific observers who can dismiss scrutiny of our values by claiming scientific neutrality and authority. Neither observer nor observed come to a scene untouched by the world*" (p.27).

As part of the quality assurance of the study, I recognised the importance of remaining reflexive throughout the research process in order to consider how my history, preconceptions, values and beliefs impacted how I planned to conduct the study, how I perceived, interpreted and presented the data (Mauthner & Doucet, 2003; Monteith, 2004; Stanley & Wise, 1983). Specifically, I engaged in memo-writing and kept a field-work diary and these activities were integral to providing me with the space for on-going reflection throughout the research, so that I could critically review my personal assumptions and reflect on my theoretical and ethical positions (Birks & Mills, 2011). I was reflexive in the design of the study as I continued to critically evaluate the approaches I took to conduct the research. For example I became aware that I needed to be more flexible in fitting in with participants in order to interview them, even if this was sometimes inconvenient for me. Importantly, this enabled participants to choose how they engaged in the research rather than me trying to dictate when interviews took place.

I was also reflexive when conducting the interviews. For example, it was usual practice that within 24 hours after having conducted each interview I documented field notes and self-reflections. These comprised my thoughts about how the interview had gone, how I felt I had interacted with the participants and what could have been done differently, my perception of the participant and whether there were any behaviours that stood out, and finally, what I believed to be the key messages arising from the interview. Documenting and revisiting these field notes were especially helpful for subsequent data analysis, whereby I read over the notes which documented the key message of the interviews in order to consider whether the themes I developed reflected these. McGhee, Marland, and Atkinson (2007) argued that reflexivity can also play a key role in

preventing a researcher who is already very familiar with the literature on the topic of study from distorting perceptions of the data or forcing preconceived concepts and theories. Thus, engaging in the process of reflexivity enabled me to be informed by and build on previous knowledge gained through the literature review, without assuming that concepts discovered in the preliminary literature review were the only solution to addressing a research problem (Strubing, 2007). I also revisited the aforementioned field notes when writing up the findings from the study and as I considered how to present and contextualise them (Downing, Polzer, & Levan, 2013). Throughout the research process I had regular supervision meetings which provided me with many opportunities to critically discuss ideas and thoughts, and to consider another perspective in relation to conducting the study, analysing the data and how I wrote up the study and presented the findings. These supervision sessions were such that I had some form of accountability whereby I was encouraged to be reflexive and to engage in discussions about the ways in which I was or was not being reflexive. Thus, the supervision sessions were another mechanism to check how I approached the study.

Throughout the research, I delivered presentations at DVA national and international conferences to academics and practitioners. This involved presentations about the design and methods of the study, the challenges of conducting the study as well as presenting my analysis of the data. These opportunities enabled me to gain feedback from experts in the field of DVA about my study and to critically reflect and respond to the feedback about how I conducted the study, my analysis of the data and how I wrote up the study.

As discussed in Section 4.5.2, the iterative process of conducting interviews and analysing data analysis meant that I adjusted interview guides accordingly. Conducting interviews and analysing data in parallel enabled respondent validation whereby I was able to check the correspondence between the developing analysis and the perspectives of interviewees in subsequent interviews (Dixon Woods et al., 2004). The iterative analysis allowed me to identify unexpected or atypical issues, and to explore these issues in subsequent interviews. Towards the end of the study I also presented my findings to the DVA organisation. This provided a useful opportunity to check out whether my findings resonated with the experiences of the service providers.

Although there has been much debate about what constitutes good standards in the methodological rigour of qualitative research, there is widespread agreement about the importance of transparent and clear reporting of qualitative studies (O'Brien, Harris, Beckman, Reed, & Cook, 2014). Therefore, when considering how to write up

qualitative work and how to maintain quality assurance, I consulted the literature discussing standards for reporting qualitative research. I have aimed to present Study 2 as clear as possible, being transparent about its aims and purpose, the qualitative approach and methods used, details of the sample and the recruitment process of participants, the methodological challenges, and data analysis. As I wanted to remain transparent about the whole research process, I found it beneficial to engage in documenting an audit trail, recording decisions I made and my rationale, even from the early stages of designing the study and deciding what methods I would use. O'Brien et al. (2014) have argued that one key strength of the reporting of qualitative studies is being explicit about the flexibility and adaptability throughout data collection and analysis. Interestingly, there has been little discussion in the literature about the methodological challenges experienced by researchers working within the field of DVA. Transparency therefore not only contributes to the quality assurance of a study, but as I hope in the case of this thesis, it will make important methodological contributions to the field of DVA intervention research. Whilst Section 4.13 discussed how I chose to present the qualitative themes in this thesis, it is also important that I acknowledge how I maintained quality assurance in the write up of the findings. As there are multiple voices in the thesis, whether this is the voice of the child, the parent, intervention provider or my own, I have been explicit about whose voice is represented.

In this section I have reviewed the ways in which I approached the conduct of the research to demonstrate methodological rigour and in light of the quality assurance literature. I revisit the quality assurance of the study in Section 9.5 of the Discussion chapter.

4.15 Reflections on conducting research with participants

There has been increasing recognition of the challenges arising for researchers involved in qualitative research, including how researchers manage emotions, maintain boundaries, and leave 'the field' (Dickson-Swift, James, Kippen, & Liamputtong, 2007). It has been suggested that the impacts associated with researchers 'leaving the field' can become especially noticeable if researchers have conducted multiple follow-up interviews with participants (Dempsey, Dowling, Larkin, & Murphy, 2016), and have spent a significant amount of time getting to know participants and have spent time interviewing in participants' homes (Dickson-Swift, James, Kippen, & Liamputtong, 2006). Researchers from a range of disciplines have written reflectively about their personal experiences of researching sensitive topics, shedding light on how they were

impacted (Darlington & Scott, 2002; Gair, 2002; Hubbard, Backett-Milburn, & Kemmer, 2001; Warr, 2004). Discussions of how researchers have responded to challenges presented in sensitive qualitative research should be documented for the wider research community rather than being ‘hidden’ and undiscussed (Scerri, Abela, & Vetere, 2012). Dickson-Swift, James, Kippen, and Liamputtong (2009) observed that the majority of qualitative researchers they interviewed spoke at length about their own emotions during their research experience. However, few researchers have written in-depth about their experiences and the problems that have arisen from them (Dickson-Swift et al., 2006; Dickson-Swift, James, Kippen, & Liamputtong, 2008). With this in mind, the following section presents post-data collection reflections, devoting attention to some of the main challenges and complexities faced during this qualitative study and how I responded to these.

4.15.1 Entering the lives of children and parents

When undertaking qualitative research, researchers enter the lives of others. Participants are invited to share their personal experiences and this may involve interviewing over an extended period of time (Dickson-Swift et al., 2007). It has been widely acknowledged that in order to build a relationship with participants in which they feel comfortable to share their stories, qualitative researchers must engage in rapport-building processes with participants (Dickson-Swift et al., 2006). Given the sensitive nature of the topic about which I interviewed participants, building rapport was crucial. However, rapport building requires researchers to empathise at a distance and engage with participants without being overly involved (Valentine, 2007).

As the majority of interviews with children and parents were conducted in their homes, I was especially aware that I was *physically* entering the private lives of participants and doing so on a number of occasions to conduct follow-up interviews. When interviewing in homes, I was careful not to rush immediately into starting the interview nor leave abruptly afterwards. In light of this, I spent time ‘chit-chatting’ with participants before the interviews started. After the interviews had ended and once I had debriefed participants, I was mindful of spending a short time with them. However, I became increasingly aware of the possibility of blurring boundaries which could communicate to participants that we had a ‘personal’ friendship. This concern was also relevant with regard to how I responded when parents asked for advice. In order to maintain clear researcher-participant boundaries whilst listening attentively and getting to know participants, I did not offer any personal advice or opinions, but rather directed participants to the DVA organisation where they could seek further support.

4.15.2 ‘Emotional’ challenges post-data collection

The process of transcribing interviews has often been viewed as a technical task, but as Warr (2004) described, transcribers are immersed in “*the voices and stories of research*” (p.586). In light of this, there has been increasing recognition that the emotional challenges associated with transcription, and the impact it has on the researcher, should not be overlooked, especially when interviews involve sensitive topics and powerful stories (Dickson-Swift et al., 2007; Stebbins, 1991).

I experienced some emotional challenges when transcribing interviews and revisiting the transcripts. These challenges were not exclusively related to the sensitive nature of the interviews, but sometimes involved my reactions to what I did or did not say in the interview, such as when I failed to ask an important follow-up question.

Emotional challenges were also experienced when I thought about the lives of participants. These were not necessarily triggered while transcribing the data or writing up the findings, but they were sometimes instigated ‘randomly’ by instances such as speaking to someone who shared the same name as a participant, or, distinct smells which reminded me of participants’ homes. Recognising these emotional impacts through reflection and documenting them in a field work diary provided me with the space and platform I needed to process and reflect on my research experiences.

4.16 Limitations of the study

Due to being unable to address the aim of Study 1, there was a need to design and conduct a second study within a short timeframe. Therefore, it is recognised that there were a number of limitations associated with the design of Study 2. As only one DVA organisation was involved, and the intervention provision of this organisation alone was specifically examined, Study 2 is highly contextual and the findings need to be considered in light of this. Although the study was exploratory in nature, there were limitations associated with the sample. With hindsight, I could have invited children who attended the interventions from ‘historical’ cohorts and their parents to participate in the qualitative study rather than depending on current cohorts. However, it is recognised that this would have been limited by the extent to which the DVA organisation was aware of whether or not it was appropriate to contact these families. I could have also made greater efforts to interview those children who had participated in the interventions on a one to one basis and those who were on the waiting list to attend the interventions. Furthermore, I could have invited a wider range of intervention providers such as commissioners or facilitators who delivered one of the interventions in

another locality and setting. However, the time constraints of the research posed limitations to pursuing these avenues. Despite its limitations, Study 2 provides a starting point for understanding the experiences of interventions that target children and young people who have experienced DVA, given the lack of good research on the services delivered in the UK and whether they meet the needs of this population.

4.17 Chapter summary

This chapter has presented an account of how I came to undertake this qualitative study and has recognised its limitations. It has discussed the theoretical background to the study, which helps the reader to understand my position as a researcher and to justify why the methods and approach to data analysis were chosen. A detailed description of the sampling and recruitment processes, the ethical considerations that are relevant to the welfare and safety of participants, as well as the researcher have also been given. Through my account and reflections on the challenges of conducting the study, I have contributed important methodological lessons for those researching with children, parents and intervention providers within the context of DVA. These lessons may provide helpful insights for those involved in conducting qualitative research with different groups of vulnerable populations. Some of the issues presented in this chapter will be further considered in the Discussion chapter. The chapters that now follow present the six themes I developed from Study 2.

Chapter 5: Intervention stakeholders' perceptions about interventions

5.1 Introduction

Study 2 aimed to examine the experiences of individuals who receive and deliver interventions targeted at children who have experienced DVA, and to identify the difficulties of demonstrating interventions effectiveness. The themes developed from Study 2 are presented across four chapters (Chapters 5, 6, 7, and 8). These themes were developed from interview data with: children and their parents involved in one cohort of Intervention A (interviews were conducted during the intervention and within one year after the intervention had finished); parents whose child was attending or had finished attending Intervention B; and the intervention providers. In this chapter, Theme 1- 'Divergent perceptions about an intervention's purpose' examines participants' views about the interventions.

5.2 Theme 1: Divergent perceptions about an intervention's purpose

There was a lack of agreement between children, parents and intervention providers concerning the role of an intervention. However, the perceptions held within these participant groups demonstrated internal consistency despite different interventions being discussed. The divergence in views is important to recognise as this may influence how individuals engage with the interventions and how they understood the success of an intervention. Within Theme 1, there were four subthemes which were as follows:

- Subtheme 1: Children acquiring clarity
- Subtheme 2: An intervention to support a child with difficulties
- Subtheme 3: A solution
- Subtheme 4: Preventing the 'cycle of abuse'

5.2.1 Subtheme 1: Children acquiring clarity

In this study the children reported that they had been uncertain about why they had attended an intervention and what its purpose was. These perceptions of uncertainty differed between children. Cinderella did not initially understand the connection between what she had experienced and her attendance at the intervention, *"At first, I thought, dad's hit mum, it's just a hit, why have I got to come here and do this because it's not helping me... I just wanted to forget all about it... I wanted to get on with my*

life.” Whilst Cinderella had felt that her parents were in more need of support than she was, it was not until halfway through attending Intervention A that she reported beginning to understand why she attended, *“I was like I actually understand why I’ve got to be here now, like I understand what’s the point in it... They [facilitators] were trying to make me understand what had happened.”* In common with Cinderella, Penny reported that her understanding of the role of the intervention became clearer over time as she developed a new understanding about her experiences, *“I had thought it was my fault, why my dad did that stuff”*. Thus, for Cinderella and Penny, their reported initial uncertainty about the role of the intervention was replaced with an understanding of DVA and their experiences. In contrast, Kwaii-Chan explained that she had always thought her attendance at Intervention A was to solve her *“anger problems”* but she remained unsure as to whether this was the purpose of the intervention right up to and including its end.

5.2.2 Subtheme 2: An intervention to support a child with difficulties

Not surprisingly intervention providers were in agreement with regard to the role of the interventions. They viewed Intervention A as helping children who had difficulties in understanding their experiences of DVA, *“understanding it’s not their fault, what’s happened, they’re not alone”* (Helen), and *“explaining why DVA is wrong... how to deal with those feelings, so we’d cover anger, but we’d do a bit around self-esteem”* (Vicky). Another role was to help *“rebuild the relationship”* (Sue) between mothers and children, a relationship that may have been affected by DVA. Intervention providers located the role of the intervention within the context of having created a *“child friendly environment, a nurturing environment...comfortable... safe”* (Eleanor). They viewed that this environment was facilitated through *“roll up blankets and cushions”* (Eleanor), *“hot milky drinks”* (Helen), and *“loads of toast”* (Vicky).

Intervention providers agreed that Interventions B and C played the role of supporting *“children who are having difficulties dealing with situations, maybe behaving aggressively or challenging towards other people, those early warning signs that they might get into trouble or move on to become perpetrators...”* (Eleanor). The emphasis was placed by intervention providers on helping children who struggled to respond to challenging situations in a healthy way, as it was presumed that children did not have the strategies they needed, *“to help children cope extremely well in adverse environments... to develop prosocial strategies for resolving [problems]... they lack the interpersonal communication skills to resolve conflict”* (Chrissie). One provider emphasised the importance of making a distinction between the child and their

behaviour, viewing the interventions as addressing problems associated with the difficult “behaviours and not the child” (Zara).

5.2.3 Subtheme 3: A solution

All parents reported, and were reported by intervention providers, to believe that an intervention would do something to the child. What it ‘did’ was presented in different ways but underpinning all views was the belief that it offered a solution which could not be achieved by the parents alone. The majority of providers reported that parents often viewed an intervention as a complete solution to their child’s difficulties, “*a lifeline...they think it will solve everything... and if that doesn’t work, nothing’s gonna work ...*” (Vicky). This was sometimes reported by intervention providers as parents “*laying all the responsibility at a child to manage their outbursts and even their own emotion...my child has got anger issues and that may be the predominant feeling, he needs fixing*” (Joe).

Intervention providers suggested that in order for parents to cope with their child, they needed to see the intervention as providing a solution, “*parents want to bring the children for you to fix them... they don’t mean that in any sort of malice way at all, it’s just their coping strategy*” (Zara). In the eyes of one intervention provider, the belief that the intervention was a “*magic wand*” reflected parents’ desire to hand over the behaviour of the child to someone else, “*they’re [parents] virtually pulling the child to assessment and we’re then confronted with a child that clearly is quite distressed about being there*” (Eleanor). However, intervention providers reported that in addition to parents, referring professionals also had high expectations of what they expected the intervention to achieve. In instances where a child had not been offered a place on an intervention, this resulted in difficult phone calls, “*we’ve had the professional phone us up and why aren’t you letting this child on or you know the parent phoning up...begging us and saying, don’t give them [child] the option*” (Eleanor).

Naomi reported that she believed that Intervention A offered her daughter the opportunity to manage her own behaviour by learning strategies or tools to manage her behaviour or through the sharing of experiences with other children, “*[Intervention A] would help to give her an opportunity to work through anything that was going on be it related to the incidents that she witnessed ...and from that give her the tools to sort of work through it...like a strategy or something she could do if she was feeling particularly withdrawn from a situation*”. Extrapolating from her personal experiences of participating in an intervention specifically for victim/survivors of DVA, Naomi believed that Intervention A would enable Cinderella to share her experiences of DVA

with other children who had similar experiences, thus viewing this as a solution, *“I think that if you’ve got the opportunity to sit with a group or on your own, with somebody who’s got this other knowledge and this other way of looking at things... to make them feel like they’re not the only one in the world whose had stuff happen to them... you can put a lot of those feelings to bed a lot quicker you know or learn from them a lot quicker”*. Jackie also believed that the intervention was a solution, and one which she believed she was not equipped to offer, *“I thought she [Kwaii-Chan] was a bit too young to understand some of it but knew that they’d [facilitators] be able to tell her in the group because they know what they’re talking about...they’re trained aren’t they to teach the young children”*.

Sometimes parents’ expectations of the intervention were based on their previous experiences of the services provided by a DVA organisation to other children. Jackie reported her son’s experience of attending Intervention A a few years before, *“It [intervention] calmed him down and made him understand a bit better what was going on because he was all angry thinking it [DVA] was his fault... getting him to understand that he can’t do that as well because he got hurt by the way he was spoken to when he was little”* (Jackie). On the basis of this experience Jackie believed the intervention would also work for Kwaii-Chan, *“...when someone mentioned it [intervention] again I thought brilliant she [Kwaii-Chan] needs that... Hopefully sort her out.”* Jackie also reported that once enrolled on the intervention, she had used the threat of reporting Kwaii-Chan’s behaviour to the facilitators as a way of interrupting what she saw as undesirable behaviour, *“I’ll say ‘if you’re going to do that when I go to [intervention] group and drop you off I’ll have a word with the people at [intervention]’, then ‘nooo! I don’t want them to know!’ and she hates the fact that I’m going to tell someone else her behaviours.”* Jackie believed that the views of the facilitators were important to her daughter and so the threat of exposure acted as a useful way of de-escalating Kwaii-Chan’s behaviour.

As stated in the intervention eligibility criteria, children and young people who experienced DVA could attend any of the three children and young people’s interventions provided by the DVA organisation. Parents believed that the amount of contact a child previously had with the DVA perpetrator was an important indicator of a child’s need for help. Parents perceived that a ‘larger’ amount of ‘exposure’ or ‘experience’ of DVA was associated with a child’s greater need for attending the intervention, because they would have experienced a ‘greater’ amount of damage. In Zoe’s mind there was a sliding scale of need among her children according to their level

of contact with the perpetrator of DVA. Penny, the child with greatest contact with the perpetrator was viewed by Zoe as having a greater need for the intervention than her siblings, *"I suppose it didn't affect them as much because she [Penny] still kept on having contact with her dad way past they did."* The fact that her siblings did not attend the intervention influenced how Penny viewed her attendance compared to her siblings, *"I don't really have a reason for them to go because they don't really have the same dad."* From Penny's point of view the biological connection she had with her father, the perpetrator of DVA, provided the rationale for her attendance at the intervention. Co-residence with the perpetrator was not deemed to be justified for other children in the home to attend the intervention.

Just as the nature and intensity of 'exposure' to DVA was associated in the minds of parents with the need for an intervention, overt and observable behaviours were deemed by parents to reflect the impact of DVA. Some of Jackie's children had not attended any intervention as they were perceived by Jackie as being able to cope because they did not *"show"* behavioural or emotional difficulties in the household. Jackie presumed that the absence of observable difficulties was testament to their ability to cope with DVA and did not need a resolution offered by an intervention of *"fixing"* or *"sorting out"*. *"How she [daughter] deals with it I don't know... but some way or another she deals with it, how I wish I knew and I could have a way of dealing with it all... She's always been quite calm but quite withdrawn, and by the time the [intervention] group was even mentioned to us, she'd sort of like managed to cope with everything"*. To Jackie, the observable and challenging behaviours of her son and Kwaii-Chan suggested that they had been affected by DVA to a greater extent because they had *"seen the most [violence]"*. The challenging behaviour was *"missing"* amongst her other children, *"They got affected by the violence or whatever obviously but they didn't really show anything or start doing anything... It had started with [son] doing that then it missed with [daughter] and then it started with Kwaii-Chan."* Interestingly, intervention providers acknowledged that where multiple siblings lived together, the intervention was preferentially offered to the child with the most overt behavioural issues, *"where you've got one who's behaviour is causing quite a few difficulties to everyone around, you may be not identifying that withdrawn child"* (Eleanor). These parental perceptions of some children being in greater need for an intervention because their outward behaviour suggested they were more greatly damaged by the DVA, is important to recognise. Parents might be more likely to dismiss the need for quieter more withdrawn children to receive help and support.

Parents of children who attended Intervention B also viewed the role of the intervention as ‘fixing’ the child. Although DVA had previously occurred in two of these families, these parents labelled their children as ‘troubled’, ‘a problem’ or ‘different’. Across parents’ representations, I observed three common assumptions. Firstly, children needed to be ‘fixed’ as a result of factors beyond their child’s control. Secondly, all the children who attended Intervention B shared certain behavioural characteristics with one another. Thirdly, parents of children attending an intervention were united in their experience of having a certain ‘type’ of child.

One parent viewed her child and the other children attending the intervention as being ‘troubled’. The negative life experiences of the child were deemed to have produced a troubled child “...each [child] are different but they stem down to the same, that the child is troubled” (Elaine). As all the children who attended the intervention were viewed in this way, Elaine felt a sense of similarity with the other parents “you know you’re not on your own...so on that point of view we can relate to each other.” The impact of being a troubled child to others was a ‘problem child’. Again, parents derived considerable relief from knowing that they were not alone. Fiona talked with a sense of relief, “you’re not the only parent that’s got the problem, as I put it, the problem child. You’re not the only one going through this, there’s others going through similar... it felt like a big weight had lifted off my shoulder” (Fiona).

In the context of ‘normal growing up’, a troubled child and a problem child was viewed by parents as a different child, a child who was marked out by behaviours which were not shared by other children of a similar age. Steve explained, “we noticed especially as he got a bit older his behaviour... was different if you like to other kids, just his anger and temper”. In common with Fiona and Elaine, Steve felt that being a parent of a ‘different’ child was a shared experience he had with all the other parents whose child attended Intervention B.

5.2.4 Subtheme 4: Preventing the ‘cycle of abuse’

Intervention A was specifically reported by parents to ‘work’ by preventing the intergenerational transmission of abuse. Zoe hoped that the intervention would challenge the example set by the perpetrator and provide the “right way” to respond to the experiences of DVA which would prevent the ‘cycle of abuse’. Zoe said, “I hope she [Penny] just realises that from the experiences that she’s had that it’s not the way to behave and she’ll grow up to be, you know, a decent adult, with decent values and views and when she has her own children, she’ll know the right way.” Zoe hoped that her daughter, Penny, would be able to recognise the signs of an abusive relationship and

avoid becoming involved in this type of relationship, *“You know hopefully she will be able to see the signs so she wouldn’t be in a controlling relationship that’s that controlling”*. Jackie reported concerns that her son would follow in his father’s footsteps to become a perpetrator of DVA and therefore felt that Intervention A was crucial to preventing this, *“I was scared that he was going to be quite bad when he was growing up and I wouldn’t know how to deal with it. But I think when he went to that [Intervention A], it, put him on a different road to where he was going. He was going more like I want to be more like my dad, angry and throwing stuff around, whereas when he went to the group, he started calming down.”*

5.3 Summary of Theme 1

A range of views were held within and across participant groups with regard to the role of an intervention. The role of an intervention to children was at the outset unclear. Most children began to understand its purpose through attending the intervention. In comparison to the children, intervention providers and parents reported having clearer ideas about the role of an intervention whereby normative constructions of childhood would be developed, although their exact views varied. There was consensus amongst intervention providers that interventions supported children with difficulties and who lacked understanding or skills. Parents viewed the interventions as a solution to something they were not equipped to manage, placing emphasis on the intervention to ‘do something’. Children who had ‘greater’ known ‘exposure’ to DVA and demonstrated observable difficulties were viewed as being in more need of an intervention which focused on recovering from DVA. Subsequently certain ‘types’ of children, were viewed by parents as needing an intervention that would address problematic behavioural characteristics, which created a sense of collective unity amongst parents. Parents also perceived an intervention to be significant in preventing the cycle of abuse. In light of the similar perceptions held amongst the participant groups and the differences in views when comparing between the groups, this may suggest that common assumptions about interventions may be associated with different intervention stakeholder groups. These differences signal that stakeholder groups are viewing an intervention from different angles which may influence how they engage with an intervention and how they understand it to be successful. Intervention providers’ awareness of parents’ divergent views yet lack of awareness of children’s uncertainty about the purpose of an intervention, raises questions about what can be done to ensure consistent perceptions are communicated between intervention providers and recipients.

The implications arising from this theme may impact the evidence base for these interventions, and thus will be examined further in the Discussion chapter.

Chapter 6: Critical components of intervention delivery

6.1 Introduction

Whilst the previous chapter discussed the range of perceptions held by recipients and providers about the interventions, this chapter discusses their views about critical components of intervention delivery. Three themes are presented in this chapter which have specific implications for how an intervention is set up and implemented. These themes are Theme 2- ‘The timing of an intervention’, Theme 3- ‘The appropriate length of an intervention’ and Theme 4- ‘The significance of who delivers the interventions.’

6.2 Theme 2: The timing of an intervention

Places on the interventions were limited and if children dropped out once an intervention had started, new children could not be substituted. Therefore, it was important to make sure that the children who attended were going to make the most of the place on the intervention. This theme comprises three subthemes regarding the best time for a child to attend an intervention during their lifetime and how this would best be screened. These were as follows:

- Subtheme 1: Sooner rather than later
- Subtheme 2: Children’s readiness to engage
- Subtheme 3: Parents’ readiness to engage

6.2.1 Subtheme 1: Sooner rather than later

Being young or receiving an intervention early, were different aspects of the same idea that the longer behavioural issues were left uncorrected or the longer children were unaware about DVA, this would lead to negative consequences. The only child to share their view about the timing of an intervention was Cinderella, who believed that there were advantages to children attending a DVA intervention when they were ‘young’. Cinderella recognised that an intervention would provide answers to important unanswered questions that should be addressed at an early stage in a child’s life, *“Even if they’re young I think they should know, like what’s going on between their mum and dad... At least they wouldn’t have to grow up like I wonder what domestic abuse was ... at least they can grow up to know what it actually was”*.

From the viewpoint of Zoe, a mother, receiving an intervention ‘early’ was important for children in order to avoid the build-up of negative emotions which might cause them to *“go off the rails”*. ‘Going off the rails’ was defined by Zoe as making

poor life decisions, making friends with the ‘wrong people’ and struggling with academic achievements, *“I think that it would have just carried on affecting her school work ... and would have struggled even more because she would have been further behind and she would have probably started making wrong choices, like hanging around people that don’t really care about getting good grades”*. A central component of the intervention from Zoe’s point of view was allowing her daughter Penny to talk about her emotions, *“The only way to stop it growing is to talk about it and sort of realise that you’re not in the wrong or it’s your fault from when you’re really young otherwise if she just kept it inside her, I think it would have grown bigger”*. Zoe also believed that as children got older they would find it increasingly difficult to deal with their feelings, *“I think if I’d just left it, it would have been harder for her when she’s growing up to deal with all the things that she’s had to put up with when she was younger”*. This idea is congruent with the findings from Chapter 5 which emphasised parents’ perceptions that an intervention was a solution.

6.2.2 Subtheme 2: Children’s readiness to engage

Running alongside this idea of receiving an intervention early, intervention providers and some of the parents’ believed that children needed to be ready to engage in an intervention. This view was shared in relation to all the interventions. However, readiness to engage was a vague concept which did not get further defined. One mother, Naomi, identified the need for the child to be *“in the right place at the right time”*, which could be measured by assessing a child’s resistance to attending the intervention. Naomi felt that if children were *“kicking and screaming”* this would indicate that they were not *“in the right place at the right time”* to attend an intervention. Naomi also suggested that it would be possible to assess retrospectively whether the child had been in the right place at the right time, by assessing whether the child was able to apply what they learned from the intervention.

Other mothers reported being uncertain as to whether or not a child’s readiness should override the need for children to get help as soon as possible. Zoe reported that Penny had not been ready to attend, *“The first couple of weeks she found so difficult that I actually thought about taking her out of it, she found it really hard to deal with”*. Zoe felt that the urgency of an intervention could override her readiness and it was preferable for Penny to *“deal with it when she’s young than when she’s older, because its best to deal with your emotions and things that you’ve been through, the younger the better.”*

Jackie reported from previous experience that her son had been put on a waiting list for Intervention A, and a place had not become available until over two years later.

By this time her son was less interested in participating, *“I think with children you need to get them in there quicker, sooner rather than later because they can change their minds and don’t want to talk to people.”* This suggested that children’s interest in participating in an intervention was important in indicating their readiness.

The majority of intervention providers reported that there was a ‘right time’ for children to attend an intervention, however this varied for different interventions. In relation to Intervention A, the ‘right time’ involved ascertaining whether the child’s circumstances had become stable, *“if they are still going through a court case, things haven’t settled down at home”* (Sandra), *“if the housing and stability of school and all of those kinds of things aren’t secure”* (Eleanor), and *“if it’s not too soon after they’ve come out of the abusive relationship”* (Eleanor). Intervention providers highlighted a key component for ensuring that children attended *“at the right time”* (Eleanor) was the DVA organisation identifying whether or not home circumstances would detract from the child’s focus on learning within the intervention. One intervention provider emphasised the importance of age in determining the ‘right time’ whereby younger children would be in a better position to engage. Younger children were described as being *“very black and white.... they know [DVA] it’s naughty, it shouldn’t have happened”* and specifically this meant that *“they’re quite ready to then move on”* (Vicky). In comparison, this intervention provider believed that older children were *“a bit more complex”* (Vicky) and were less prepared to ‘move on’ as easily, although it was not suggested what could be done to address this.

Intervention providers specified that a child’s ‘readiness’ to attend Interventions B and C was when a child acknowledged that an intervention would help to address a ‘problem’ associated with their behaviour. Providers reported that this was currently assessed by asking the child questions such as, *“do you acknowledge you’ve got an issue with your behaviour?”* or *“do you want to change?”* (Mike). The extent to which children acknowledged the ‘problem’ was deemed as irrelevant, *“... it doesn’t matter how much they’re acknowledging just as long as they’re aware there is a problem that needs addressing”* (Mike). In instances where there was uncertainty about a child’s motivation to attend, opportunities could be arranged for further exploration, *“... if we’re still a bit unsure at the end of the screening... whether they want to get a change out of it we’ll invite them in for a one to one interview”* (Mike). Another intervention provider suggested that a child’s readiness would emerge over time as they attended the intervention, as it would be possible to assess whether the child was attending *“for the right reasons”* (Joe). These views were based on experience and reflected that the

intervention did lose children after they had started attending the intervention, *“I think at least 2 of them would have dropped out had they had the ultimate decision, I think there was pressure from parents to give it another go”* (Joe). In light of the findings from the previous chapter which highlighted that children acquired their understanding about the purpose of an intervention as they attended it, the expectations for children to demonstrate their readiness prior to the intervention could be an over-ambitious expectation of intervention providers.

6.2.3 Subtheme 3: Parents’ readiness to engage

The majority of intervention providers reported difficulties with the extent to which parents engaged with the intervention. Interestingly, this was not something that the parents identified. Intervention providers recognised that parents’ readiness to engage was important in the timing of an intervention. In the context of DVA, some parents were perceived as still dealing with their own experiences of DVA as victim/survivors and were described as being on their *“own journey of recovery”* (Zara). This ‘journey’ was understood to impact the extent to which parents were ready to engage with an intervention that was designed to support their child and include them in this, *“sometimes they find it really, really difficult to have those conversations... they don’t understand it [DVA] themselves or it [intervention] just opens up a lot of things that they’re not ready for”* (Zara).

Intervention providers perceived that parents’ attendance at parent sessions was a primary indicator of parents’ engagement with the intervention and in supporting their child. There was consensus amongst intervention providers that parent sessions were designed to help parents support their child at home, with the expectation that parents should be willing to play an active role in supporting their child, *“a lot of the children come into the group, all this work is done with them but then they’re being sent back into the same environment that they were in before ...whatever you’ve got in place will fail after a period of time”* (Simone). Intervention providers viewed parents’ engagement in parent sessions as desirable because it enabled a parent to better support their child, *“the best outcome is when the child is supported by the parent and the parent is engaging”* (Eleanor).

While acknowledging the importance of parents attending the parent sessions, there was no attempt on behalf of the intervention providers to tie parents into attending the sessions. One mother explained how parent sessions for Intervention A had been cancelled when a number of parents contacted the DVA organisation as they could not attend. In response to this, facilitators visited all parents in their own homes to relay the

information they missed, *“The first one [parent session], quite a lot of people couldn’t come. It was going to be cancelled, but because I was so close to the group that they said oh just come along... the second time I got a phone call saying that so many people cancelled... so they came to me”* (Zoe). As there were no adverse consequences of non-attendance at parent sessions, parents might have inferred that attendance was discretionary. As there were fewer planned parent sessions compared to the sessions for the children across the interventions, it was not clear whether this sent a signal to the parents as to the value of these sessions. One facilitator in another job had experienced being part of a team where parallel children and parent sessions were delivered at the same time *“we did a group with the children and two of us did the group with the parents alongside each other... they were both benefiting and then going home”* (Sandra). In this way the resource implications for parents were minimised. However, the costs of doubling the number of facilitators had been deemed too expensive for this model to be adopted for the three interventions provided by the DVA organisation.

Some intervention providers reported that parents who were not willing or ready to engage would *“always find reasons... they’re always going to come up with an excuse”* (Zara) for not attending parent sessions. However, they also recognised that some parents had work or child care commitments that made it difficult for them to attend, *“They work and struggle to take time off so... I appreciate they’ve got work and things”* (Vicky), *“many of the parents that we have it’s not the only child, they’ve got 3 or 4, so its juggling child care”* (Mike). In an attempt to be accommodating, some intervention providers reported that they rearranged when parent sessions were delivered in order to encourage attendance. However, this adaption did not always improve attendance, *“When we do sessions in the day it’s not helpful if they work, but we do sessions at night but they’ve still not come, possibly because they been at work all day”* (Mike).

While intervention providers expressed concerns about parents’ engagement in relation to parents’ non-attendance at parent sessions, the parents in this study acknowledged the sacrifices that they and other parents made to bring their child to the intervention. Reflecting how they viewed the critical importance of their child’s attendance in light of an intervention being a solution, their willingness to engage was demonstrated through their commitment to bringing their child to the intervention. In some cases, this involved travelling a considerable geographical distance, *“I was surprised when some of the other parents had said how far they’ve come... quite a long way really”* (Steve). Cinderella recognised that getting to and from the intervention was

not easy for all the other children participating in the intervention. While Naomi transported her each week, Cinderella explained that this was not the case for all children, as she recalled other children reporting to her that *“my mum didn’t wanna drop me off today”*. This caused Cinderella to be concerned that other children might think that she *“didn’t have it as hard as they did”*, because her mother showed a willingness to support her by transporting her to the intervention.

Some parents struggled financially in getting their child to and from the interventions *“Financial support would have been a massive help because of fuel... it’s a lot travelling”*. (Fiona). The cost of travelling to and from the intervention had the potential to influence whether the child attended the intervention, when there were competing demands on a limited budget, *“we’re going camping this weekend. I was thinking should I cancel so I’ve got extra money for the weekend”* (Zoe). Some intervention providers recognised the financial burden of the intervention on parents in relation to transport costs *“we shouldn’t be expecting our parents to be paying out”* (Sandra), and where households did not have access to their own car and public transport was limited in rural areas, there was a reliance on taxis, *“Parents have struggled... one parent is spending £20 a week on transport just to attend this group”* (Sandra).

However, the sacrifices some parents made in transporting their child to and from the intervention was not always fully appreciated in light of the wider implications this had. For one parent, travelling to the intervention was complicated by her own mental health issues, but despite these personal difficulties this mother was determined to do this for her son, *“I’d go to the moon and back if it helped. You’d walk on hot coals if it helped your son feel better about himself or your daughter... You can’t stop being a parent, just because you’re feeling a bit low, we have to carry on and it was a case of sink or swim”* (Elaine). For some parents, the practicalities of transporting their child to the intervention often entailed arranging the care of other children not attending the intervention. Some parents reported that other children ‘missed out’ because of the parent’s commitment to getting the child to the intervention. Parents explained this to their other children by explaining *“he needs my help as well, it’s not just you”* (Fiona).

As intervention providers primarily viewed parents’ engagement in relation to their attendance at parent sessions, there was a lack of appreciation for the factors that contributed to parents experiencing difficulties when supporting their child at home. When Naomi initiated conversations with Cinderella about Intervention A she was dissatisfied with Cinderella’s responses, *“She didn’t really sort of talk about anything... She used to just talk about what the other kids were like, she might say just about how*

they are within the group... or what they had for snack". Naomi reported that she did not want to *"probe too much... I didn't want to sort of encroach"* on something that was *"personal"* for Cinderella, preferring that her daughter initiate any discussion about the intervention. All the parents of children who participated in Intervention B reported having difficulties in supporting their child because their child appeared confused about the sharing of information. The intervention was packaged as 'private and confidential' and as a result, parents felt left out of the child's experience of the intervention. This proved to be a missed opportunity to build on the work that the intervention providers clearly envisaged would go on at home between the child and the parent. Steve said *"... he's not told us much about it because it's been really secret, only for him"*. Elaine experienced a similar scenario *"...he doesn't really tell me much about the sessions, he just says private and confidential"*. Fiona had also encouraged her son to share what he had learned at the intervention but similarly had struggled to engage in communication, *"He doesn't tell me anything about what they've done, at all. It's confidential. I'm like, you can tell me a little bit, can't you? Nope."* However, parents had not reported communicating these difficulties back to facilitators.

6.3 Summary of Theme 2

Interventions were perceived as being necessary to meet their purpose but were often viewed as best timed during the earlier stages in a child's life, in order to ensure a positive impact on children's future life experiences. However, there were tensions between prioritising prompt intervention timing with the readiness of children and parents to engage with an intervention. This raises questions about whether being ready and willing engage may be used in some way to ration services available to children and how readiness can be defined and assessed prior to an intervention starting. As discussed in Chapter 5, parents viewed an intervention as a solution. When considering this in light of Theme 2, this contextualises parents' readiness to engage with an intervention by making sacrifices to transport their child to the intervention and attempt to engage in discussions about the intervention with their child. Intervention providers primarily perceived a parent's non- attendance at parent sessions as showing a lack of willingness to engage and not necessarily appreciating the context in which parents faced challenges in supporting their child. These components of the appropriate timing of an intervention in the life of a child could have implications on whether all children referred to an intervention are given the same opportunity to participate, and question

what steps can be taken to ensure consistent expectations regarding intervention engagement, particularly in relation to the role of parents.

6.4 Theme 3: The appropriate length of an intervention

Children, parents and intervention providers had different perceptions about the significance of the length of interventions. Both children and parents would have liked the intervention to be longer, but for different reasons. Whilst children wanted a longer intervention in order to prolong the positive experiences of participating in the intervention, parents felt that a longer intervention would produce more long-lasting outcomes. Intervention providers acknowledged the limitations of short interventions but recognised that they were designed to provide a short-term input into the life of a child. This theme comprised the following two subthemes which demonstrate the range of views about the impact of an intervention's length:

- Subtheme 1: Prolonging intervention experiences
- Subtheme 2: Prolonging the durability of intervention outcomes

6.4.1 Subtheme 1: Prolonging intervention experiences

All three children who attended Intervention A felt that the intervention was too short. This was underpinned by a desire to continue experiencing the positive aspects of the intervention. For Kwaii-Chan and Penny these positive experiences related to the interactions with other children. The intervention was described by Kwaii-Chan as *"funner than here [home]"* because *"I always get bored when I'm not with people."* Penny *"didn't really want it to be over"* due to the fun she had while attending the intervention and she wanted to continue to share her feelings and experiences of DVA with the other children. Penny talked about the negative experiences she had at school when children had laughed at her when she shared her experiences of DVA. Initially, she had been reluctant to share her experiences at the intervention, but when she observed that *"no one else has laughed"* at the intervention in response to other children sharing their experiences, she began to *"trust them [the other children] ... at the end [of the intervention] I like kind of talked"*. Cinderella proposed that a longer intervention would have enabled her and the other children to continue learning more about DVA, and specifically to *"know more about like different kinds of abuse"*.

6.4.2 Subtheme 2: Prolonging the durability of intervention outcomes

Parents appeared unaware of where the intervention fitted into the overall range of services that might be accessed by their child. All parents reported that a short

intervention would result in short-term outcomes, whilst longer interventions produced more durable outcomes. Jackie expected that Intervention A would ‘sort out’ Kwaii-Chan and this would be evidenced in a reduction in Kwaii-Chan’s challenging behaviour. Jackie felt that the intervention *“worked at the time... and for about 3 months after...now and again it has worked when I’ve mentioned the place [intervention]...it hasn’t worked in the long term... It hasn’t worked properly in her”* due to *“it ... getting bad again with the behaviour”*.

With the passage of time since the intervention, Naomi felt that Cinderella had forgotten some of the things that she had learned from Intervention A, *“she gets very stressed and very panicky and she sort of turns the blame round because you’re trying to give her some helpful advice... I feel like she needs like a little refresher”*. Naomi identified the possibility of using resources associated with the intervention as a way of refreshing Cinderella’s memory of the course content with the view that it would result in having a long-term impact, *“maybe the book [Talking to my Mum] would be a good idea...or maybe her folder from the course...to look back and think... just to jog her memory”*.

Following Penny’s completion of Intervention A, a Common Assessment Framework (CAF) was put in place in which *“all the agencies that can offer interventions and support”* (Eleanor), were available to her. Zoe felt that if the intervention had been longer, the CAF might not have been necessary, *“I think just a little bit longer... for the ones that needed it a little bit more”*. She suggested that, a longer intervention would be effective if the extra sessions took place shortly after the main intervention had been delivered, so that children could consolidate and build on their learning without having too much information to take on board in a short time period *“...they could have realigned themselves with all the information that they’ve been given rather than have too much.”* Fiona also appeared to express uncertainty about the durability of the strategies learned by her son during Intervention B, *“I’d love it [the effect of the intervention] to last... for him to literally calm down upstairs, do his breathing and his counting to 10 backwards, and come downstairs and say sorry mum I shouldn’t have spoken to you like that”*. She perceived that her son attending either another intervention, as a continuation of Intervention B, would help to ensure the long-term impact of the intervention, *“I would like [son] to do another one, a follow up”*. Again, in light of parents’ perception of an intervention being a solution or as a prevention from the cycle of abuse, it is fitting that they perceived a longer intervention to be more effective than a shorter one.

Despite the interventions being short, providers emphasised that an intervention should not be viewed as a “*quick fix*” (Helen). In the context of children understanding their experiences of DVA, intervention providers reported that a 12-week intervention such as Intervention A was “*a drop in the ocean*” (Helen). As a result of this, facilitators reported that they would need to consider recommending a child to access “*further support*” (Vicky) post-intervention. In the context of DVA, intervention providers viewed an intervention as “*the beginning*”, with the expectation that children usually needed to receive further support to continue understanding and work through their experiences of DVA, “*We just don’t want to leave them [on their own]*” (Vicky). However, as parents and children did not acknowledge their awareness of further support services this questions the extent to which parents and children were aware of the range of services available to support children who had experienced DVA.

6.5 Summary of Theme 3

Amongst the three participant groups, it was reported that longer interventions were important although the reasons underpinning this varied between the groups. While the children had enjoyed their participation in the interventions and wanted these positive experiences to continue, parents were uncertain as to whether it had been long enough for the sustainment of the positive changes that emerged whilst children attended the intervention. Intervention providers recognised that the brevity of an intervention could make it seem as though it was a quick fix but acknowledged that the interventions played a short-term role. These perceptions hold important implications for understanding how outcomes are viewed in light of intervention length, and for how interventions are designed and developed, as intervention length can communicate messages about how an intervention is located in the life of a child. If intervention providers recognise interventions as having a ‘short-term’ role, then this also has implications for the range of services that are available and accessible to children who have experienced DVA.

6.6 Theme 4: The significance of who delivers an intervention

The specific individuals who deliver an intervention was seen as making an important contribution to the delivery of an intervention. These contributions are presented through the following two subthemes:

- Subtheme 1: Facilitators’ characteristics

- Subtheme 2: Experience of working with children

6.6.1 Subtheme 1: Facilitators' characteristics

Across all participant groups it was acknowledged that the characteristics associated with facilitators were important, because they influenced how children and parents engaged with them. A few facilitators reported that it was advantageous for interventions to be delivered by a team of facilitators who had different personalities, in order to reflect the different types of children attending the intervention, *"the benefit of having 3 facilitators in our case is that we have a different way of speaking with and working with children"* (Joe). One specific characteristic isolated by an intervention provider as important to any facilitator delivering Intervention A, was being nurturing, *"the nurturing side of it I think is key to it with the right people doing it... it's just people's nature"* (Helen). This attribute was identified as being innate to the facilitators rather than something that could be taught through training.

One parent highlighted the importance of facilitators being non-judgmental, due to her previous experiences of talking to other professionals within the context of DVA and feeling judged and blamed as a mother. Jackie had perceived some professionals as *"speaking down"* to her, which made her feel *"a little bit small"*. She attributed this to professionals speaking to her as though *"you've just come out of a domestic problem household"*. In contrast, the facilitators spoke to her in such a way that she felt like *"a normal person... rather than... oh there's one of the mums who's been battered or something's happened in the house and that's why her kids here"*. However, Jackie still found it difficult to trust facilitators due to experiencing circumstances where trust of her child's safety had been breached by the DVA perpetrator. However, Jackie was encouraged by the group-based nature of the intervention to trust the facilitators because there was some form of accountability, *"it was like safety in numbers"*. From Naomi's perspective as a mother, she was confident that facilitators were not a threat to the children as they had *"gone through the right sort of process in being able to be there to deliver the course"*. Cinderella reported that she felt comfortable and physically safe in the company of the facilitators, *"The people just made you feel safe, I would always feel safe there with them"*, as she inherently perceived the facilitators as responsible adults who could help protect her, *"you could tell you were safe with them."*

All parents felt that the ideal facilitator was someone who could draw upon their personal experiences, *"somebody ideal for that job, would be somebody that's been through everything they're actually talking about... somebody who's actually been*

through it all so...they have a better understanding of it and more of an understanding of parents and children” (Jackie). Whilst experiencing such personal circumstances was not a requirement for being a facilitator, parents viewed those facilitators who shared personal experiences with them as being easier to relate to as they demonstrated having a better understanding of the issues discussed. Parents viewed this as important in contributing to the credibility of what facilitators said to parents during informal conversations or at parent sessions. However, parents perceived facilitators who did not draw upon these personal experiences or did not have them, as *“reading from a textbook”* (Elaine) and were subsequently less relatable.

One intervention provider highlighted the importance of facilitators being open minded and responsive to feedback given by children, parents or another facilitator about the delivery of the intervention. Facilitators demonstrated their openness by prompting feedback, *“asking the children along the way, okay are we doing it right, are we doing it fast enough for you, are you bored...getting as much feedback as you can whether it’s from the children or the parents or the co-facilitator”* (Zara). Facilitators reported that it was important to remain open to the possibility of doing things better and *“not being complacent that you’re the best”* (Zara).

The children compared their experience of the facilitators as more favourable than their experience of school teachers; teachers seemed to offer the closest comparator as people in authority who were not family members. Cinderella described facilitators as being *“nicer than teachers”* because of how they engaged and communicated, *“Teachers like nag nag nag. They [facilitators] were a lot nicer so like they were there to help us learn about it but in a different way to what a teacher would”*. Furthermore, Cinderella felt that unlike teachers, facilitators *“...actually listen to you”* and *“.... answer properly back to you”*. Kwaii-Chan felt that the facilitators talked to her *“properly”* as if she was a ‘grown up’. This helped her to engage with the facilitators more fully. Some facilitators reported that a desirable facilitator was someone who delivered the interventions in a way that contrasted to children’s expectations of teachers *“I think that’s one of things they’re expecting of you, that teacher role. I think someone that’s able to have a laugh and a joke and not react to them as they want to”* (Mike).

6.6.2 Subtheme 2: Experience of working with children

Having experience of working with children was also deemed central to the facilitator role. It was viewed by children, parents and intervention providers that facilitators’ experience of working with children equipped them to communicate and

engage with children and respond to any communication challenges in light of the “...development of children and having some awareness of the different abilities of children and the different ways any communication difficulties can be overcome” (Eleanor). Cinderella reported that this experience would enable facilitators to communicate to children with clarity. Cinderella recalled, “*The volcano helped me to not hold my emotions in... it was basically telling us if we didn’t tell people like how we feel about stuff that’s basically what would happen inside our heads and it will all come out at once like if you’re angry and sad*”. She believed that having a strong understanding about the meaning underpinning a ‘fun’ activity needed to be communicated well by facilitators, and this was critical to ensuring the effectiveness of the activity, “...even though it was fun I still remember the meaning of it... I think that’s because they explained it as well as when we were going along”. Interestingly, the facilitators viewed this activity as the least helpful “*I think the volcano one was one that facilitators...didn’t really feel that the children always got the messages and the aims of what that session was trying to do*” (Eleanor). Another ‘fun’ activity recalled by Cinderella was one that she believed was less clearly explained by facilitators with regards to its purpose and she thought it was “...probably one of the activities that I don’t think really helped.... It didn’t do anything” (Cinderella).

Stakeholders viewed the physical safety of the children as important, but in relation to facilitators successfully managing group dynamics amongst children, “*I think to be a facilitator on any group you have to have some knowledge of group dynamics and managing a group [of children]*” (Eleanor). The significance of facilitators’ experience of working with children meant that facilitators would be better equipped to “*manage conflict or behaviour*”, in a “*safe way*” (Joe).

6.7 Summary of Theme 4

Children, parents and intervention providers emphasised that individuals who delivered an intervention were critical to the successful delivery of an intervention. They viewed that the way in which intervention facilitators interacted with the children, with parents, and other facilitators could influence how interventions were delivered and how individuals engaged with an intervention. Facilitators’ prior experience of working with children, how they communicated with children and how they managed the intervention group was also viewed as being critical. These components may have important implications for informing how facilitators are trained and recruited, of which will be explored in the Discussion.

Chapter 7: Evidencing intervention effectiveness in practice

7.1 Introduction

This chapter presents Theme 5- ‘Barriers to evaluating interventions’ which discusses the difficulties of evaluating and demonstrating the effectiveness of the three interventions, using the methods described in Study 1. There were a range of factors hindering the extent to which the data could be robustly collected and easily interpreted.

7.2 Theme 5: Barriers to evaluating interventions

The majority of intervention providers expressed concerns about experiencing barriers to evaluating interventions. These are best understood in light of the following six subthemes:

- Subtheme 1: Limited engagement with intervention evaluation
- Subtheme 2: Using the ‘wrong’ tools
- Subtheme 3: Unmeasured outcomes
- Subtheme 4: Accounting for intervention adaptability
- Subtheme 5: Practical constraints of intervention evaluation
- Subtheme 6: Barriers to joint-working

7.2.1 Subtheme 1: Limited engagement with intervention evaluation

Intervention providers often reported that children and parents, alongside parents’ non-attendance at parent sessions, did not engage fully with the intervention evaluation activities. However, this view primarily arose in relation to the timing of a final evaluation questionnaire (Tool D) which was distributed to children during the last session of Intervention A. Over time this last session had become a ‘party day’ for the children, *“I think we had balloons, we had some snack like popcorn”* (Kwaii-Chan); *“We basically just had a party... I think we played games... I think we did a bit of work and then however long we had left we could go outside and play games”* (Cinderella). Although facilitators acknowledged that asking children to complete the questionnaire during this session was unrealistic given what else was going on, the timing of when this tool was administered still continued *“they’re doing it on the wrong day because they don’t want to be sitting there on the table doing that”* (Helen).

Follow-up sessions of Interventions B and C were reported as providing an opportunity for children and parents to complete evaluation tools and provide feedback for intervention development, *“I did a follow up session with two of the children that*

completed Intervention B and that's a question that we ask them [how activities have helped them]" (Emma); *"they say some sessions were too long"* (Joe). However, facilitators reported difficulties in engaging families to arrange follow-up sessions which presented a barrier to collecting post-intervention evaluation data *"even after the programme they can be a bit resistant engaging"* (Joe). All intervention providers anticipated that conducting a longitudinal evaluation of all the interventions would be beneficial, but based on the difficulties in collecting one-month post intervention data, they anticipated that this was unlikely to be successful, in light of having limited resources to pursue this, *"I would like to do a longitudinal evaluation... but...you'll only capture a percentage of the people that have finished working with you... getting people [to engage] is a nightmare"* (Simone); *"by that point, we're onto the next group"* (Sue).

Some intervention providers reported that not all facilitators were fully engaged in the evaluation process as they were not 'signed up' to collecting data in a rigorous and robust way, *"The facilitator... only photocopied every third sheet so every back sheet was missing"* (Chrissie). Not only did they view these facilitators as undermining the data collection process, but one intervention provider reported that this sent a strong signal about the value of the data, *"a child who has gone through and answered those questions that are quite upsetting and quite personal for nothing"* (Chrissie). One facilitator who was not employed by the DVA organisation reported that they often forgot to send back evaluation data to the DVA organisation, *"I always forget to send bits [evaluation data] to them"* (Helen).

7.2.2 Subtheme 2: Using the 'wrong' tools

As described in Chapter 3, the SDQ (Tool A; Goodman, 1997) was used in Study 1. However, intervention providers specifically identified this tool as being the 'wrong' tool to evidence outcomes for the interventions, because sometimes the scores from the SDQs presented a different picture of the impact of the interventions compared to anecdotal feedback from parents. Intervention providers perceived these differences as a weakness of the SDQ, *"I'm just not convinced that that's the right tool because we can observe change in the children and we can have change reported by parents on an ad hoc kind of informal basis, but that's not reflected in what we're seeing in terms of the strengths and difficulties"* (Simone).

Despite the perceived limitations of the SDQ, providers still considered the tool as the best available tool, *"the strengths and difficulties questionnaire... which is a bit naff... It's better than anything we've got"* (Vicky). Those facilitators who had delivered Intervention A in its previous configuration, had also used the SDQ to assess

intervention outcomes. History and tradition seemed to frame and justify the use of the SDQ “...that’s what it’s always been and that’s what we’ve always done to measure the outcomes” (Vicky).

7.2.3 Subtheme 3: Unmeasured outcomes

Intervention providers viewed the evaluation tools as being collectively limited, because they did not measure some of the outcomes that they perceived to be important in evidencing the effectiveness of the interventions. Interestingly, intervention providers’ views about unmeasured outcomes were informed about their perceptions regarding what was meaningful to measure, as opposed to children and parents’ views on outcomes. For example, there was no tool that was perceived to measure children’s resilience, “*I would like to have tools in place to show that children were more resilient and able to cope with the challenging situations post- programme than they were pre- programme*” (Simone). Intervention providers also viewed the outcomes of an improved relationship between children and mothers as being central to Intervention A “*to reconnect the mother and the child...because often their relationship has been damaged though the domestic abuse process*” (Sue). However, an intervention provider reported that this outcome was only explored using a non-standardised tool in the form of one question in Tool C which asked mothers, “*Do you think your relationship with your child has changed as a result of the group?*”(Helen). She suggested that asking a straightforward question to the child could capture some insight about this, as asked in Tool D, “*can you talk to your mummy about what happened any better?*” (Helen), although children’s perceived lack of engagement in completing the tool may have made this difficult to capture.

7.2.4 Subtheme 4: Accounting for intervention adaptability

The interventions were set up as being adaptable to meet the needs of the children. There were different ways to adapt the interventions and there were factors which affected the decision to do so, which could affect how the interventions were delivered and experienced.

7.2.4.1 Factors influencing a decision to adapt an intervention

Facilitators expressed that there were a number of factors which influenced their decisions to adapt an intervention. Their decision making was primarily influenced by their familiarity, experience and confidence in delivering the interventions, children’s responsiveness, and the perceived relevance of intervention content.

Facilitators across all the intervention had been encouraged in their intervention training to be creative in how they delivered the sessions, as long as the aims of the

sessions remained consistent with those in the intervention manuals, *“the sessions aren’t set in stone that you have to do that activity for that aim or message”* (Eleanor). Facilitators’ familiarity, experience and confidence in delivering an intervention provided the basis for adapting intervention sessions, *“You don’t have to stick to those activities... I think it’s up to how confident a facilitator is”* (Mike); *“it comes with experience and confidence of doing groups... also the facilitators feeling comfortable with what they’re delivering”* (Eleanor).

Facilitators reported that regular delivery of an intervention provided them with a platform from which they could be flexible in adapting intervention sessions, *“There would be flexibility if you knew the programme well, if you did it regularly”* (Sandra). The intervention author of Interventions B and C viewed those facilitators who showed initiative and creativity in adapting the intervention as demonstrating expertise. They believed that expertise developed over time as facilitators gained experience in delivering an intervention, *“they’re embedding that framework and that knowledge and actively using it and thinking about it, they’re not just doing what it says on the paper... You know they’re really processing it... after three years I’m seeing expertise”* (Chrissie). As facilitators’ experience with the interventions was perceived by intervention providers as associated with the extent to which they adapted the sessions, this had implications on how teams of facilitators were put together when new facilitators started delivering interventions, *“we wouldn’t put two newly trained facilitators on a programme so we would always have an experienced facilitator when we are using new facilitators”* (Eleanor).

Some facilitators reported that their experience of regularly facilitating with the same group of facilitators encouraged them to be flexible and make adaptations. The extent to which facilitators were familiar with each other in this capacity was understood as helping them to work effectively as a team, picking up on cues that emerged from the children during the sessions; *“because we’ve been doing it for so long I think... we pick up on stuff, non-verbal cues from each other, things the children don’t say... I think that, we’re just very good at it”* (Helen).

Facilitators reported that the extent to which they adapted the interventions was also influenced by other facilitators sharing their own experiences of delivering the intervention with them. However, this was only observed in relation to Interventions B and C. Facilitators and the author of Interventions B and C, exchanged information about the adaptations that had been made. When the intervention author perceived specific adaptations as particularly helpful, she circulated these examples to the other

facilitators. She also included these suggestions in updated versions of the intervention manual, *“wherever we’ve had really good ideas from other facilitators I’ve tried to write those in and include them in the manual”* (Chrissie). Facilitators reported feeling inspired to incorporate different techniques and activities into their own practice as a result of delivering interventions with different facilitators and discussing their experiences of delivery, *“I’ve had the benefit of doing some cover sessions in other groups and I’ve brought techniques back, they do that and that works very well and I’m going to try it and it’s the only way you learn so, being able to share experiences can only enhance it”* (Joe).

Another factor that influenced whether interventions were adapted was children’s ages and stages of development. In light of this, facilitators reported that they needed to remain mindful of the needs of each cohort, *“it’s being able to be flexible and adapt your approach really to the children that are in that group, whether they’re the younger end of the age range, or the older end, y’know you’ve got to be able to match”* (Sue). This involved facilitators making an intervention *“more bespoke to participants”* (Joe), for example varying the type of language used when communicating to the children, *“Going to the child’s level. Making it child friendly”* (Sandra), and adapting the types of activities included in the sessions *“...there are some obvious activities that might not work for that age group”* (Joe).

Facilitators also reported adapting both interventions in light of how children responded and engaged during an intervention session. For example, the format of activities was often adjusted to the preferences of the children, *“You might get a really crafty group... the facilitators pick up on those kinds of things...or this group aren’t really into craft, so we need to look at role play and acting out”* (Eleanor). Sometimes, certain activities were introduced or removed from a session in light of how children had been engaging, *“...there’s things we review and add in or take out if kids don’t respond to it”* (Vicky). Facilitators explained that on some occasions, they had adapted the structure of a session with the purpose of encouraging the children’s engagement, *“we adapted it to the way the kids were responding...because the kids were so hyperactive... we would do 20 minutes of focused activity and then 20 minutes of some kind of game or activity they could burn off steam”* (Chrissie). Facilitators also made spontaneous adaptations in light of what the children had requested them *“It’s having the ability to adapt to the situation... if they want to revisit something we did the previous week, or maybe a couple of the children weren’t there the previous week and so they missed something, we’ll go back”* (Sue). The most common form of adaptation was introducing

new visual tools or exercises that children could easily engage with, *“different exercises, visuals, techniques... most of the changes are more inclusive of different learning styles and to make some material as engaging and interactive as possible”* (Chrissie).

There was consensus amongst some facilitators that because Intervention A was *“designed ages ago,”* (Helen), the intervention content needed to be updated *“...the material needs updating massively...there’s lots of children now where the domestic abuse isn’t just from father to mother and that’s how its set up... it just needs updating to represent across the board”* (Vicky). Content that facilitators viewed as being irrelevant was excluded when the intervention was delivered, *“...there was a session on gender very much on man, woman, builder, teacher, but now it’s not like that anymore so we scrapped that and thought they’re not getting anything out of that so we focus on feelings in that session”* (Vicky).

7.2.4.2 Maintaining intervention integrity

Those providers who were involved in delivering intervention training explained that when facilitators attended training, they were encouraged to be creative and responsive to their intervention cohort, whilst not compromising the goals of each session, *“the training is encouraging people to be creative and to use that session for those aims and purposes”* (Eleanor); *“I always encourage them to be responsive but not undermine the goals of each individual session... your key learning point for each session is your bedrock, not to be altered”* (Chrissie). However, some intervention providers presented concerns about how adapting an intervention could compromise the integrity of the interventions and therefore affect the outcomes. One example related to dedicating a greater amount of time within one of the sessions of Intervention B, to those activities that children particularly engaged well with. This limited the time available to deliver the remaining content. From Joe’s experience of *“running out of weeks”*, some sessions were combined, *“so there were some sessions where it [amount of information] might have been overwhelming them [children]”*. In order to ‘catch up’ in this way, trying to deliver multiple sessions in the space of one session may have compromised intervention integrity.

Some intervention providers recognised that monitoring intervention integrity was important in light of how the interventions were adapted across cohorts and amongst different groups of facilitators. Whilst individual facilitators updated aspects of the content of Intervention A that they thought were out of date, these changes were not necessarily implemented across all the cohorts. Therefore, certain changes to the intervention were specific to those cohorts associated with particular facilitators. The

impact of making these adaptations to the intervention on outcomes is not known. As discussed in Chapter 6, one critical component of an intervention related to facilitators being open to receiving and responding to feedback. Thus, it was paramount for all for these adaptations to be accounted for in order to monitor intervention programme integrity, especially if facilitators were trained to be responsive to feedback.

Only intervention providers in relation to Interventions B and C discussed the monitoring of intervention integrity. The intervention author systematically recorded what adaptations had been made and why, *“The way that I’ve collected feedback on a lot of those changes is either through supervision, or through the development days, where we’ll talk about oh I did this exercise like this, or I found this video clip”* (Chrissie). However, there were some instances when Chrissie reported that the adaptations did compromise intervention integrity, as some facilitators were observed to ‘pick and choose’ certain aspects of the sessions they delivered based on their own personal preferences, *“The main issue that I’ve encountered is that they don’t do all the content so I’ll have particular exercises and they don’t like them... and ones that are their favourite, so that could be an integrity issue”* whereby the intervention is *“moulded...to the learning style of the facilitator, not the child”* (Chrissie).

7.2.5 Subtheme 5: Practical constraints of intervention evaluation

Eleanor described the commissioning of the interventions as *“timed pieces of work”*, because the timeframes and financial resources associated with the provision of the interventions dictated the extent to which intervention providers could be involved in post-intervention data collection. The time limited nature of the funding also influenced timeframes within which outcome data needed to be collected. Furthermore, some facilitators had limited additional time to give to the intervention evaluation processes as they were external to the DVA organisation and needed to prioritise other commitments.

Intervention providers argued that there was no funding in place to support both the provision and the evaluation of the interventions, *“there’s absolutely no capacity financially to have a post that looks at data and looks at impact and outcomes”* (Simone). Subsequently, the execution of evidencing the outcomes was *“down directly to the commitment of the people who are involved delivering the work”* (Chrissie) which consisted of a small number of individuals employed by the DVA organisation adopting unsustainable practices in collecting the data, *“chasing around... for weeks and months...trying to get information”* (Simone). Furthermore, it was perceived that commissioners did not always recognise *“the process of gathering and analysing and reporting”* outcome data *“or ask...how do you measure [an outcome], what tools would*

you use, how do you know that it's genuine?" (Simone). In light of the limitations of the tools used to assess effectiveness of the interventions, the DVA organisation began to explore the implications of using alternative tools, although it was unclear as to whether there were sufficient resources to implement them, *"we're in discussions about whether we do them [implement a specific tool] with every child or not because they're quite a big piece of work"* (Eleanor).

Intervention providers perceived that collecting post-intervention evaluation data would be facilitated if it was embedded in wider multi-agency working to optimise the use of all available resources. They viewed that if other agencies were in a position to share information about children, such as which school a child attended, this would increase the likelihood of being able to collect post-intervention data *"The local authorities...education committees should be giving us that access... even if it is can you tell us what school they're at... we should be doing more work with social care and education about tracking children"* (Carol).

7.2.6 Subtheme 6: Barriers to joint-working

Facilitators' experience of delivering the interventions was heavily influenced by how the interventions were coordinated and managed by the DVA organisation. In particular, this affected joint-working and communication between facilitators, and how they understood their role as 'facilitator'. Intervention providers identified that a key factor affecting joint-working was whether or not facilitators were employed directly by the DVA organisation. One facilitator reported that because he and his co-facilitators were all employed by the DVA organisation, this enabled them to easily communicate in advance of the weekly intervention sessions, *"...usually I've met with the other facilitators a few weeks before to decide who's running each session"* (Mike). The benefit of facilitators communicating with other facilitators meant that they were each prepared to deliver the weekly intervention sessions. There were often cases where the facilitator team comprised individuals who were employed by the DVA organisation and those who were not. In these 'mixed' teams, those who were not employed by the DVA organisation reported feeling less prepared because they had communicated less with those facilitators who were employed by the DVA organisation.

Intervention providers expected that facilitators across all interventions would receive supervision to support their role. For those facilitators employed by the DVA organisation, supervision was often facilitated and integrated into meetings which related to the children and young people's work they were involved in at the organisation *"every week, me, Emma, and Eleanor as the youth team come and discuss*

all our referrals and all the work we're doing" (Mike). However, this pathway to supervision excluded their co-facilitators who were not employed by the DVA organisation, *"we don't do anything else as a group with all the facilitators"* (Mike). As a result, this hindered joint-working as there were few opportunities for mixed groups of facilitators to *"discuss with each other in an environment where ...you're not rushing off anywhere and you've just got to think about each child and how the groups progressing"* (Sue). Sandra's co-facilitators were employed by the DVA organisation, and she felt isolated from them as she was not involved in the informal conversations they had about delivering the intervention, *"I suppose because they work together and I came in, then I wasn't involved in the same discussions"* (Sandra). Taking into account that all facilitators had a range of other work commitments, it was not surprising that facilitators reported that there was limited time to have discussions before and after the sessions, regarding how the sessions would be run and how facilitators could support the children, *"It's work commitments again isn't it, I've missed that because I like to know what I'm doing with the session... we finish... the children need to get home, there's no time for feedback... we don't know if those children should have a visit in the week or a phone call"* (Sandra).

A few facilitators who were not employed by the DVA organisation reported that they used the individual supervision they received through the organisation that employed them to facilitate intervention supervision. However, the individualised nature of the supervision process for facilitators not employed by the DVA organisation had limitations, *"I have supervision with my line manager every 4 weeks because I do a lot of safeguarding work so I get it...but she doesn't know the children I'm working with does she, she doesn't know"* (Sandra). In light of group supervision facilitating the monitoring of intervention integrity, it can be questioned as to whether individual supervision is an appropriate alternative which enables the consistent and effective monitoring of intervention integrity.

Some facilitators felt that as a result of not working for the DVA organisation, there was a lack of communication with the organisation about the practicalities of delivering an intervention which contributed to intervention facilitators feeling unprepared. Examples of these included, identifying the exact location of where the intervention sessions would take place, organising resources for each session, and arranging transport for children to attend if this was needed, *"Do you know what would be nice [to help in our role as facilitator], if you weren't worrying about buildings, if you weren't worrying about taxis"* (Sue) and *"none of this- we haven't got the right*

equipment, we haven't spoken to the parent, is it the right child coming to the right group" (Helen).

One group of facilitators reported that changes to facilitators' responsibilities presented another barrier to joint-working and communication. All of the facilitators who had delivered Intervention A when it had been previously provided by the national organisation, identified changes in their responsibilities as a result of the DVA organisation now being commissioned to provide Intervention A. Facilitators universally articulated these changes as a 'loss' in how they saw their role. This created barriers to effective joint-working with members of the DVA organisation. Previously, under the coordination of the national organisation, facilitators had been personally involved in actively processing referrals for Intervention A, selecting the most suitable cases for the intervention through reviewing the cases and conducting assessments with children prior to the intervention. When the DVA organisation became responsible for coordinating the interventions, the DVA organisation took over this active management of the referrals.

The facilitators recognised that because the DVA organisation had become directly accountable to the commissioners, they now managed all of the referrals because *"They've got to have it for their figures for you know and they've got to hold the referral"* (Sue). However, facilitators still wanted to remain involved in the referral process as part of their role as facilitator, *"we've worked in this area for so long...we'll go, 'massive family' 'I know who you mean', and we know who they are, and we know there's been domestic abuse in the family and how the kids would benefit from nurturing and the programme"* (Helen). These facilitators reported that their lack of involvement in actively managing the referral process affected their relationship with the children. Facilitators explained that conducting assessments as part of the active management of referrals was an important component of building trust and familiarity with children and parents, *"if we did the assessments...they would have met us a few times then... it's nice for the child to know at least one of the facilitators before they've come into the room"* (Vicky). They perceived the assessment process as providing an opportunity for facilitators to gain a detailed understanding of each child, *"I don't think I spoke to the child properly"* (Sandra). Having an understanding of the *"backgrounds of children"* before working with them in the intervention was believed by facilitators to assist in knowing whether *"what they're saying is linked to anything... what issues they've had... what frightens them"* (Sandra). However, the intervention coordinator reported that facilitators' knowledge of too much information rather than knowing too little could present a barrier to them supporting the child, *"if you know too much... You can be a bit*

pre-judgmental of what you want that child to gain... I don't think you need to have spent a lot of time getting to know that child, I think that's part of the process while you're on the group" (Eleanor).

7.3 Summary of Theme 5

There were a range of challenges associated with demonstrating intervention effectiveness. Intervention providers acknowledged that the extent to which children and parents engaged with intervention evaluation negatively impacted the likelihood of data being available to demonstrate intervention effectiveness. This was particularly problematic for collecting post-intervention data, thus, limiting the examination of long-term outcomes. Intervention providers were also perceived as having varied levels of engagement in evaluation, which could impact whether data was collected robustly. Therefore, identifying how intervention evaluation engagement is sustained amongst intervention stakeholders is crucial for demonstrating intervention effectiveness. In addition to this, the tools used to measure intervention outcomes were perceived as being limited in demonstrating intervention effectiveness as well as some outcomes not being measured by any tool. Whilst interventions were set up to be adaptable and there was recognition of ensuring intervention integrity, there were factors impacting the extent to which adaptations were made, which may have impacted intervention delivery and intervention effectiveness. Furthermore, it was unclear whether there were consistent processes in place to monitor the integrity of all the interventions in light of adaptations. Due to the nature of how the provision of the interventions were funded, this impacted the timeframe for which intervention effectiveness needed to be demonstrated, further limiting the likelihood that long-term effectiveness could be assessed. Moreover, the lack of resources allocated to intervention evaluation meant that there were unsustainable ways of the DVA organisation working to evidence intervention effectiveness. Stemming from a need to maximise resources, the joint-working collaboration of delivering interventions by involving individuals employed and not employed by the DVA organisation, was challenging in light of an organisational divide. This impacted both communication and an understanding of roles, which may have affected intervention delivery and the robust collection of evaluation data.

Chapter 8: Using qualitative methods to explore intervention outcomes

8.1 Introduction

The qualitative interviews facilitated important discussions about intervention outcomes. This chapter explores how the qualitative interviews were beneficial in understanding outcomes. This chapter presents Theme 6- ‘The contribution of qualitative methods in examining intervention outcomes’.

8.2 Theme 6: The contribution of qualitative methods in examining intervention outcomes

Intervention providers reported that the tools administered to measure intervention outcomes (outlined in Chapter 3), only demonstrated a partial understanding of the impact of the interventions, *“I don’t believe the tools that we’ve been using adequately demonstrate the difference that has been made”* (Simone). These limitations were also evident when the data from these measures were compared with the interview data. One mother, Jackie, reflected that her participation in the qualitative interviews impacted how she viewed intervention effectiveness, *“it [Intervention A] helped a lot more than I actually thought, now I’ve been speaking about it”*. This suggests the importance of considering what methods are used to explore intervention outcomes and how this may impact perceptions about intervention effectiveness. The qualitative interviews enabled a richer understanding of intervention outcomes and are discussed in the following three subthemes:

- Subtheme 1: Prioritising the voice of the child
- Subtheme 2: Situating outcomes in context
- Subtheme 3: Identifying unanticipated intervention outcomes

8.2.1 Subtheme 1: Prioritising the voice of the child

The qualitative study (Study 2) enabled children to share in their own language their experience of an intervention, in such a way that could not be captured through the outcome measures. The evaluation tools, as used in Study 1, appeared to mould the voice of the child into key thoughts and feelings. One intervention provider observed that Tool D did not prioritise the voice of the child as it limited the amount of feedback from the children, *“it’s one-word answers isn’t it, but it’s not really what you want but it would be good if you could get more from them”* (Helen). In contrast, the qualitative

narratives of children allowed the voice of the child to frame their own meaningful outcomes of participating in an intervention.

Illustrating this, Penny thought she was to blame for the DVA incidents that occurred in her family, *"I thought it was my fault, why my dad did that stuff"*. From attending the intervention, she learned that *"it isn't my fault, that I'm not alone"*. Penny described the impact of now understanding that it was not her fault, *"I used to like wish I died and all that... now I feel like I don't want to kill myself anymore and I don't want to run away... Now I feel happy... because it's let go."* Penny also explained that during the intervention she had begun to communicate her feelings with an animal puppet that she had 'befriended' at the intervention. Without this puppet she *"wouldn't have talked to anyone... I would have done that [looked down] not talking, just sit quietly just listen to other people"*. Upon leaving the intervention the facilitators gave Penny the animal puppet to keep, which Penny reported that she used as a coping strategy outside the intervention environment, *"I always whisper to it to him about how I feel about dad."*

From Cinderella's perspective, hearing other children's experiences of DVA had helped her realise that she was not *"the only person"* who had experienced it. This enabled her to appreciate her own family situation, *"If you'd asked me before, I would have been really sad and annoyed about it... if you'd ask me now, I'm happy? I'm happy with what I've got... when I listened to everyone else's [experiences]... I was like... wow, people have worse families than me"*. Cinderella felt that attending the intervention was *"probably the best 12 weeks of my life.... when my dad hit my mum it was probably the worse 40 minutes of my life.... so to know why he did it what happened and what it was and how to solve it if it actually happened again was good... that's why it was the best 12 weeks of my life."* Through understanding her experience of DVA, Cinderella reported that she grew to care about DVA, *"when you've been through it, and you've learned about it... you actually care what it is"*, to the extent that she wanted the opportunity to help other children to understand DVA and be equipped to know what to do if they faced a similar situation, *"It would be nice to go into school one day we have PSHE and they do... domestic abuse if it happens to someone else I would prefer if they knew what to do."*

As staff employed by the DVA organisation recognised that there were limitations associated with how outcomes were measured, the DVA organisation had been involved in developing an outcomes framework for all of the interventions provided across their organisation. Surprisingly, the DVA organisation had not directly consulted the children, but rather relied on their perceptions regarding what outcomes

children were likely to perceive as being meaningful, *“It wasn’t that we asked the children... it was all the staff, and what they were doing is looking at what children want...putting yourself in their shoes, then putting yourselves in the facilitators shoes, then putting yourself in practitioners, then a manager’s and then a funder’s so you walk through all of those to come out with what [outcomes] you want”* (Eleanor). Intervention providers’ decision not to directly consult the children was reflected in other ways. For example, when introducing the child-led ‘Talking to my Mum’ book, facilitators reported that they did not *“physically give it [the book] to the children, we give the book physically to the adult... we don’t talk greatly to the child about it, so we tell them that there’s a book... whereas with the parents we do a session talking specifically about the book and how you know they can support the child...we don’t do that level of content...that detail... with the child... we don’t all sit down and have a look at a copy [with the children] together”* (Eleanor).

8.2.2 Subtheme 2: Situating outcomes in context

The qualitative narratives highlighted that factors mediating intervention outcomes could not be accounted for using the outcome tools, as these did not situate outcomes in context. These will now be discussed using three examples.

8.2.2.1 Physically travelling to and from the intervention

The qualitative narratives demonstrated that the journey travelling to the intervention enabled Jackie and Kwaii-Chan to talk to each other and resulted in an improvement in their relationship. Jackie was the only parent who reported that this *“special time”* each week helped to develop their relationship. Jackie welcomed this opportunity as she found it difficult to spend time with each of her children, *“trying to take one out without the other is a bit hard... it would just be me and her going from school...and on the way, we’d stop off at the shop and get some sweets and a treat...that no one else had, so she enjoyed that because it was our one to one time.”* However, once the intervention had ended, Jackie said that their *“special time obviously...stopped”*. In this example, the intervention helped to create a context in which the mother-child relationship could develop. However, as a result of the intervention ending, this opportunity was removed. Thus, by Kwaii-Chan attending the intervention and Jackie transporting her, this enabled opportunities for their relationship to develop which were not necessarily accounted for by the tools used in Study 1.

8.2.2.2 Using an optional intervention resource

As part of Intervention A, the ‘Talking to my Mum’ resource aimed to support the rebuilding of the parent and child relationship through facilitating conversations

about their experiences and feelings about DVA. However, facilitators had not followed-up how this book was actually being used and how it impacted the mother-child relationship, due to being mindful as to whether parents would respond to follow-up, *“we don’t do that follow up afterwards and see how much, and we know how much parents are given documents and books and letters and things”* (Eleanor). However, the qualitative interviews with children and mothers explored how this resource was being used in the home, how it could be beneficial, and identified the barriers to engaging with it.

Zoe reported that the book facilitated communication with Penny, *“It helped me understand her feelings a lot more... Before the programme, I only knew how she was feeling from her behaviour...”* (Zoe). Using the illustration of a tree, Zoe described how the book helped Penny communicate her thoughts and feelings to Zoe: *“...I asked her whereabouts she was on the tree... before she started this group... she was sitting on her own and I was sitting on the tree, she thought I was the stronger one on the tree...halfway through [the intervention] she said I was the one that was helping her up on the tree now and I was the one giving her the lift up and when she’d finished [the intervention] she said we were both sitting on the tree together”*. In an interview with Penny where Zoe was also present, Penny struggled to articulate her viewpoint. In response to this, Zoe suggested phrases that she believed might reflect what Penny wanted to say. Penny responded to Zoe’s help and said, *“When I did that how come it sounded confusing and when mum said it was not confusing?”* Zoe believed that having worked through the book with Penny, this facilitated her understanding of Penny, *“I feel like I knew what you were trying to say... doing the programme with you and the writing in the book I sort of know from that kind of thing what you mean.”*

Kwaii-Chan reported that she appreciated working through the book with Jackie as it helped create a space that was for her and Jackie, *“It was just for me and mummy to do. I did some bits on my own but when I got stuck... on something like a word... mummy helped me”*. From Jackie’s perspective, the book helped her better understand how Kwaii-Chan felt, *“I think there’s a lot in it [Talking to my Mum book] that parents don’t think about... we had moved around a lot because of what had happened so there was one in there about leaving your home and your friends and how you felt... and she put down what she missed and what have you...learning things about your own kids that you don’t really know.”* However, Jackie reported that her experience of working through the ‘Talking to my Mum’ book posed a barrier that had not been raised by other mothers. Jackie explained the difficulties of engaging with this resource when coming

across activities in the book that referred specifically to the DVA perpetrator, *“there were some bits we didn’t talk about in there because they were a bit raw over dad”* and therefore these activities were *“avoided”*.

In contrast, Cinderella did not want to engage with the ‘Talking to my Mum’ book for the reason that she perceived the book format of the resource as a barrier to engaging with it, compared to an electronic format, *“I was like ok thanks for the book I guess...I don’t find books fun.”* Whilst this impacted the extent to which Naomi and Cinderella used this resource, it did not create a barrier to developing their relationship, *“We’ve been talking a lot about different stuff and she is very open, she doesn’t say I don’t wanna talk, you know, she won’t hide herself away, she will come and talk to you”* (Naomi). Thus, understanding outcomes such as the improved mother-child relationship is important to locate and understand contextually.

8.2.3 Subtheme 3: Identifying unanticipated intervention outcomes

The findings from the qualitative interviews identified that there had been outcomes experienced by parents that had not been anticipated nor measured by intervention providers. However, this was somewhat inconsistent with intervention providers’ emphasis on the role of parents in supporting children through an intervention (as discussed in Chapter 6) which may inevitably lead to impacting the lives of parents. Parents whose child attended Intervention A, reported experiencing outcomes that related to their own developed understanding about DVA. Parents’ accounts varied about how their understanding of DVA had changed and what they believed had mediated this change. Jackie reported previously believing that DVA consisted only of physical abuse between parents, however through talking to Kwaii-Chan, her understanding developed, *“I thought domestic violence was them watching mum and dad beating each other up... but she [Kwaii-Chan] came out and explained all that to me.”* Through communicating with Kwaii-Chan, Jackie also developed an awareness of her children’s experiences of the DVA incidents that occurred in the family home that she had been previously unaware of, *“I didn’t know the kids knew what was going on... they were out of the way as far as I was concerned, they didn’t see or hear anything.”*

Zoe reported that she had conversations with the facilitators to gain an understanding about *“what is a violent relationship...what is a normal relationship... the statistics of how high domestic violence is in the country”*. Developing an understanding of these things enabled Zoe to understand what she had personally experienced *“...just the conversations with them [facilitators], has helped me understand and let go even without doing a group [intervention].”*

Naomi explained that she had previously attended her own DVA recovery intervention prior to Cinderella attending the Intervention A. As a result, Naomi reported that she had gained an understanding of DVA through attending the intervention which had helped her *“break things down of how they happen and how I might have felt at the time but not really understood... just being able to accept it and acknowledge it and then just leave it behind”*. Naomi did not report an improvement in her understanding of DVA through Intervention A, but recognised the improvement was facilitated through previously attending an intervention for victim/survivors.

8.3 Summary of Theme 6

A qualitative approach to exploring intervention outcomes can be invaluable. Although the findings presented in this chapter were specific to Intervention A, there are transferable applications to other interventions. The qualitative approach prioritised the voice of the child, accounted for factors mediating outcomes, and identified unanticipated outcomes. When given the opportunity, children articulated in their own language their personal experiences of an intervention within 12 months of having participated. This theme has demonstrated that there can be complexities associated with interpreting outcomes without situating them contextually. Identifying unintended outcomes question whether they should be measured, particularly if these outcomes are viewed as being meaningful to an individual. These findings have implications for the methods used to identify what outcomes are meaningful to stakeholders and why, how outcomes can be measured and accounted for in light of contextual factors, and outcomes that may not have been previously considered. In light of limited intervention timeframes and resources as highlighted in Theme 5, it may be challenging to implement qualitative methods during an intervention and after it has finished. However, it is important to consider the invaluable role of qualitative research in evaluation contexts for developing an intervention evidence-base. The implications of this will be explored in the Discussion.

Chapter 9: Discussion

9.1 Introduction

In this thesis I have presented the development of two studies focussed on interventions available for children and young people who have experienced DVA. Whilst one of the interventions was targeted exclusively at children who had experienced DVA, two interventions were open to children with a range of experiences including DVA. Study 1 aimed to explore the effectiveness of three interventions targeted at children and young people who have experienced DVA using standardised and non-standardised tools. Given issues arising from the use of these tools and the limitations that the available data imposed on understanding intervention effectiveness, Study 2 was developed. Study 2, a qualitative study aimed to explore intervention recipients and providers' views about their experiences of an intervention and to identify the difficulties of demonstrating intervention effectiveness. Study 2 is one of the few studies to date that has qualitatively examined what is important to key stakeholders involved in delivering and receiving an intervention available for children who have experienced DVA. This study is also unusual because it includes the voices of children under 12 years old who have shared their experiences within one year after having participated in an intervention. This final chapter considers the implications of both studies, the contribution they make to our understanding of DVA interventions and the strengths and limitations of the research. In addition, this final chapter identifies recommendations for theory, policy, practice and future research. There were common threads that emerged and resurfaced across the observations and results from Study 1 and Study 2. This chapter presents these as three meta-themes which are as follows: 1) The value of the voice of the child; 2) A lack of appreciation for divergent views; and, 3) The impact of organisational context.

9.2 Meta-theme 1: The value of the voice of the child

As discussed in Chapters 1 and 2 the voice of the child is traditionally absent in DVA research and DVA intervention evaluation studies. Study 2 contributed to the limited research that has explored children's experiences of attending interventions in light of DVA (Callaghan & Alexander, 2015; Cater, 2014; Howarth et al., 2016; Humphreys et al., 2011; McManus, Belton, Barnard, Cotmore, & Taylor, 2013; Peled & Edleson, 1992; Pernebo & Almqvist, 2016; Thompson, 2011).

How the voices of the children in Study 2 were heard contrasted with the methods used in Study 1. Although children were invited to complete intervention evaluation tools in Study 1, the design of these tools created boundaries within which children were encouraged to contribute their views. This raises the questions of how the quest for standardisation in evaluation tools potentially mutes the voice of the child. Whilst intervention providers acknowledged barriers to children's engagement in completing the tools, there had been few attempts to address these barriers in practice. Study 2 provided a less restricted platform for children to share their experiences, which suggests that the methods used to capture the voice of the child are of paramount importance. This emphasises the importance of standardised tools not only demonstrating intervention effectiveness but prioritising the voice of the child. The implications of these for practice will be further explored in Section 9.6.3.

Study 2 demonstrated that if given the opportunity, children can provide powerful evidence of their experiences. Children critically reflected upon their experiences of the intervention in which they participated and discussed how their understanding of DVA had changed over time. Similar observations regarding children taking an active role in interviews have been made in studies that have explored children's accounts of DVA (for examples, see Callaghan et al., 2017b; Evang & Øverlien, 2014). This supports the argument that children can articulate their own experiences in ways that make them competent informants in qualitative research (Dockett & Perry, 2007; Spratling, Coke, & Minick, 2012) even in light of having experienced DVA (Baker, 2005; Øverlien, 2010).

Listening to the voice of the child can enable DVA interventions to be co-produced potentially making the experience of an intervention more meaningful for children. In Study 2, the children experienced an intervention in ways that contrasted with their parents and intervention facilitators. For example, the children and facilitators differed in those intervention activities that were thought to be meaningful and useful. Moreover, facilitators placed an emphasis on the 'Talking to my Mum' book as part of Intervention A, yet, barriers to engaging with its 'book format' have not been previously reported in relation to this resource (Humphreys et al., 2006a; Smith, 2016). Children also provided important insights regarding the characteristics of individuals delivering the interventions. Again, this remains an under-explored area within DVA intervention research (Howarth et al., 2016).

In relation to children and young people, the term co-production has been used when referring to their engagement in participation activities (Tisdall, 2017). However,

the findings from this thesis emphasise the value of not only consulting with young people but placing the significance of their experiences to inform the delivery of voluntary or public services (Stephens, Ryan-Collins, & Boyle, 2008).

A surprising finding from the interviews with the children was the initial lack of clear understanding about why they attended their intervention. Similar findings have been reported with regard to children arriving at a shelter or refuge unaware of the DVA which triggered their arrival (Peled, 1998). However, over the course of the intervention children developed an understanding of DVA, they reported coming to an understanding that they were not to blame for the DVA that instigated their participation in the intervention. This had positive life changing implications on the children as they no longer reported feelings of shame or guilt, but started to experience a sense of hope, a finding of which has been identified by children in previous intervention studies (Callaghan & Alexander, 2015; Paris, 1998; Peled, 1998; Peled & Edleson, 1992). Children's lack of clarity about attending an intervention raises important questions about the extent to which children should be aware of the purposes of an intervention before attending or whether this understanding should be allowed to emerge over the course of the intervention (Cater, 2014). Furthermore, it raises the question as to whether intervention readiness can be determined by children's understanding about an intervention prior to participating in it, a question of which may contribute to informing discussions about measuring intervention readiness, in light of the lack of well-validated tools that measure readiness (Howarth et al., 2018).

Whilst intervention providers acknowledged the short-term nature of interventions, parents and children identified the value of longer interventions. Whilst parents believed that longer interventions would increase the durability of intervention outcomes, children reported that length of interventions should take account of the different rates at which children are able to develop trust with other children in the group. For some children in Study 2, the child's engagement increased once they had got used to the other children in the group and felt safe, but this was near the end of the intervention, supporting previous research (Callaghan & Alexander, 2015; Howarth et al., 2016). Children enjoyed the intervention and reported that a longer intervention would also enable further educational opportunities for them to learn about abuse, and to develop resources to raise awareness of DVA to their peers as a response to how they cared about DVA. Study 2 demonstrated that when children are consulted they reveal many ways in which they can draw upon their experiences to developing an intervention and contribute to the issue of DVA at a population level.

9.3 Meta-theme 2: A lack of appreciation for divergent views

In order to capture a range of views regarding intervention effectiveness, the tools administered in Study 1 were intended to be completed by children, parents and teachers. Study 2 demonstrated the value of qualitatively exploring stakeholder views rather than restricting this to reporting outcomes alone. Study 2 enabled a more nuanced understanding of how intervention stakeholders experienced the delivery and receiving of an intervention and how there was breadth and disparity in perspectives even regarding the same intervention. The different views held between and within stakeholder groups demonstrate that an intervention will be viewed from divergent angles. These divergent views are important to recognise as they influence how individuals choose to engage with an intervention, how children are likely to be supported outside of the intervention environment, how an intervention has been experienced, what is believed to be an important component of intervention delivery and how individuals perceive the importance of evaluation data. As discussed in Chapters 1 and 2, the adult voice is often privileged in DVA intervention research. However, as observed from Study 2 inviting parents and intervention providers to articulate their views beyond the boundaries of outcome reporting, can enable their perspectives to be understood in their wider context and to identify where divergent views have not been recognised.

The qualitative findings from Study 2 provided a different way of understanding some of the responses captured through the tools in Study 1 and highlight how this thesis demonstrates the importance of exploring what intervention outcomes mean to intervention stakeholders, and obtaining feedback about methods used to evidence outcomes. Study 2 demonstrated that whilst intervention providers used tools to demonstrate the effectiveness of their service of which they had little faith in demonstrating intervention effectiveness, these tools continued to be implemented. It was recognised for example that key intervention outcomes such as resilience were not measured due to a lack of validated tools, which has been identified elsewhere (Dannerbeck, Casas, Sadurni, & Coenders, 2004; Howarth et al., 2015; Windle, Bennett, & Noyes, 2011). However, recognising intervention providers' views about this is paramount, as it should contribute to informing the development of what tools are used to evaluate interventions. Study 2 also enabled unexpected outcomes of an intervention to be identified which is important when considering what additional outcomes should be measured. The outcome of parents developing an understanding about DVA had not

been considered by interventions providers but had been identified by parents. Furthermore, there was a lack of appreciation for how parents struggled to communicate with children in the home environment about the intervention in light of how children interpreted the ‘private and confidential’ aspect of an intervention. Thus, understanding the context in which divergent views are held demonstrates the complexities in interpreting reported experiences of an intervention as well as outcomes. Moreover, the lack of appreciation of the divergent views held amongst intervention providers with regard to the importance of robustly collecting evaluation data, provides important insight regarding the limited data available in Study 1 (this will be further explored in Section 9.6.3).

How children were perceived in relation to an intervention demonstrated the implications of stakeholders not appreciating different viewpoints. In this small-scale study, children who appeared to be angry or unable to control their emotions were perceived as behaving inappropriately. They were subsequently referred to an intervention tailored for those who did not meet diagnostic criteria for a disorder. Those children who were quiet and withdrawn, displaying more ‘appropriate’ and ‘acceptable’ behaviours, were not viewed as needing to attend an intervention, because they were perceived as being resilient in the face of adversity (Howell, 2011; Martinez-Torteya et al., 2009).

Parents held the assumption that an intervention provided a solution and could restore or fix their child, both in cases where children had or had not experienced DVA. The idea of the reversibility or restoration of the child, as indicated through an improvement in the child’s behaviour, emphasised parents’ assumption that children could be fixed within the boundaries and environment of an intervention. This assumption also impacted how parents viewed the urgency of an intervention and how a longer intervention was associated with a greater durability in outcomes. Subsequently, parents often made sacrifices to address financial, transport and childcare barriers that prevented a child’s attendance at an intervention, barriers of which have been previously reported (Howarth et al., 2016; Peled & Edleson, 1992; 1999). Identifying how parents perceived children and an intervention provides an important contribution to contextualising how parents demonstrated their willingness to engage with an intervention. However, intervention providers did not always recognise the significance of the sacrifices made by parents, which overlooked parents’ commitment to the intervention. If these had been recognised they should be used to counter the perceived lack of parental engagement. Although intervention providers expressed hopes that

parents would participate in a parent group, they still held the expectation that parents would not attend in light of viewing parents as relying on children's attendance at weekly intervention sessions as a solution to a problem. Intervention providers reported that parents' lack of attendance at parent sessions did not result in their children being excluded from accessing the intervention sessions. Thus, children's eligibility to attend an intervention was not determined by how many sessions their parents had attended. Although not directly reported by parents, it is possible that this may have communicated to parents that these sessions were merely optional. Recent research has proposed that a range of modifiable factors can address children's and parents' readiness to engage in an intervention which can be extended beyond focusing on individual factors (Howarth et al., 2018). However, establishing little appreciation of divergent views and not attempting to reconcile these differences may lead to intervention stakeholders engaging with interventions in such a way that can lead to misunderstandings about intervention engagement and this may influence how outcomes are reported and interpreted.

Whilst intervention providers did not view the children as requiring fixing through the interventions, they proposed that the children attending an intervention were either damaged due to their experiences of DVA or lacked the appropriate strategies they needed to develop healthy relationships. This reiterates the assumptions held about a normative or 'right' childhood which can be communicated through interventions in the production of 'good outcomes' for children (Callaghan, Andenaes, & Macleod, 2015). The outcomes measured in Study 1 and the findings of Study 2 suggest that children's existing ways of coping were not recognised and interventions were seen as providing children with healthy strategies that they lacked. This approach to viewing a child and intervention contrasts with how an intervention could alternatively be founded on recognising and building upon children's existing ways of coping (Callaghan & Alexander, 2015). Whilst children were positioned as passive recipients of an intervention in this way, the findings from this thesis have also observed an expectation that children will also develop a set of skills to establish healthy relationships. This presents mixed messages about whether a child takes a passive or active role in relation to an intervention. A lack of clarity about this may be detrimental to how an intervention is delivered and how expectations of intervention engagement are communicated.

9.4 Meta-theme 3: The impact of organisational context

There is a paucity of DVA intervention research which has identified that the organisational context in which services are delivered can either facilitate or hinder the delivery of interventions. It has been recognised that organisations which have strong leadership and are well-resourced are better positioned to deliver interventions, compared to organisations characterised by staff shortages, inadequate funding and chaotic working practices (Humphreys et al., 2011). It has been reported that if an intervention is situated in a broader community response and there is multi-agency buy in, this can also impact the credibility and sustainability of an intervention. Having a multi-agency team that can deliver interventions for children who have experienced DVA has been acknowledged as providing a positive asset, in light of facilitators having different styles of intervention delivery, experience and knowledge (Sharp, Jones, Netto, & Humphreys, 2011). It has also been acknowledged that DVA organisations are responsible for influencing practitioner or facilitator readiness to deliver an intervention (Humphreys et al., 2011). Stanley et al. (2015) recommended that before an intervention is delivered there should be *“an alignment of those delivering the programme with the philosophical assumptions and norms that underpin it”* and for *“some kind of maturity matrix to assess organisational readiness to implement and be aligned to a future programme”* (p.76) as well as ensuring consistent management practices (Howarth et al., 2016). However, research on DVA interventions has broadly ignored the impact and role of organisations in shaping how interventions are delivered (Howarth et al., 2018).

Specifically, the findings from this thesis make important and unique contributions to understanding what is currently known about the role of organisational context by proposing that an organisational setting can have specific implications for joint-working, service provision and evaluation practices. The DVA organisation in this thesis sought to maximise resources for their commissioned delivery of the interventions primarily through recruiting intervention facilitators who were employed by the organisation, as well as those who were not but had prior experience of delivering one of the interventions. However, there were difficulties of joint-working particularly between those employed and not employed by the DVA organisation. There has been substantial research into multi-agency team working outside of the DVA context, whereby effective teamwork requires all members to have team situational awareness to address responsibilities. Having a knowledge of team roles, capabilities and interpersonal relationships (Berggren, Johansson, Baroutsi, Turcotte, & Tremblay, 2014), along with

an element of shared situational awareness across members to promote coordination in a task (Cooke, Kiekel, Salas, Stout, Bowers, & Cannon-Bowers, 2003) have been identified as important to ensuring effective teamwork. Concepts such as familiarity and trust have been identified as important for improving information sharing (Jarvenpaa & Keating, 2011; Ren & Argote, 2011). Establishing effective communication practices, having a joint understanding of roles and making deliberate intentions to share knowledge is paramount in the provision of a service. This becomes especially important when individuals who provide that service are employed by different organisations, whereby communication and understanding the roles of individuals may place greater demand on effort and resources.

In light of the findings from Study 2, effective teamwork may have been difficult to establish due to the physical and psychological distinctions between those employed or not employed by the DVA organisation. Challenges to joint-working may have contributed to the difficulties associated with intervention evaluation. The limitations associated with the data available in Study 1 were contextualised in light of the findings from Study 2, due to limited engagement and commitment of intervention providers to collect robust evaluation data, and the DVA organisation having no capacity to develop sustainable evaluation practices.

In light of the findings from this thesis, the application of Weick's (1976) framework of organisational structure within the specific context of any DVA intervention provides a novel contribution to understanding DVA interventions. Although Weick's (1976) framework set out to describe organisational structures in educational settings, it has been applied in the field of computer systems, criminal justice (Alarid, Sims, & Ruiz, 2011; Johnson & Vaughn, 2016; Sharp, 2009) and healthcare organisations (Pinelle & Gutwin, 2006). Weick (1976; 1982) proposed that structures within organisations can be tightly or loosely coupled. The term 'coupling' is used to describe the linkages and the strength of linkages between organisational structures. Weick (1976) postulated that a tightly coupled organisation has a set of mutually understood rules enforced by an inspection and feedback system, whereby components are centralised and so closely connected with each other that a problem in one part of the system affects the ability of other parts to function. In contrast, a loosely coupled organisation has been described as having disconnected components and if problems in one area occur, they can be contained and do not affect the functioning of the rest of the system. Moreover, this model of organisation it is adaptable to diverse environmental changes and flexible to suit the needs of a customer (Alarid et al., 2011).

However, a loosely coupled system may result in a patchwork of inconsistent services which differ according to the location and people delivering the service (Weick, 1982). Weick (1976) proposed that two or more independent agencies could work together to pursue a common goal, whilst remaining physically and organisationally autonomous. Based on this definition, a ‘loosely coupled’ system could also be described as agencies that collaborate or work with other organisations, such as the DVA organisation working with individuals employed by other agencies to provide interventions. When elements are loosely coupled, interdependence between the elements is reduced (Weick, 1976), and interaction between elements is usually infrequent (Hasenfeld, 1983), indirect and occasional (Weick, 1982).

Local-level adaptation of DVA interventions has been recognised as important for maximising effects and encouraging ongoing sustainability (Bisset et al., 2013), although the extent to which complex interventions can be adapted to suit different contexts, whilst maintaining their integrity has been debated (Moore et al., 2015). In the context of the findings from Study 2, elements of a loosely coupled system were observed, as there were inconsistencies associated with how intervention integrity was monitored across the three interventions in light of making local-level adaptations, which could have impacted the outcomes reported in Study 1. Whilst Weick (1982) proposed that loosely coupled organisations could be advantageous in meeting the needs of ‘customers’, this can be seen in the loosely coupled approach to intervention adaptability. Thus, adopting inconsistent and loosely coupled practices in monitoring intervention integrity may have meant that if a full set of data had been available from Study 1, there would have still been difficulties in ensuring robust intervention effectiveness.

In the case of facilitators who were not employed by the DVA organisation, the concept of decoupling which is a consequence of loose coupling (Weick, 1976; 1982), may be significant. Decoupling involves individuals becoming more autonomous, leading to the creation of their own personal goals, policies, customs, and practices that diverge from the larger organisation’s (Johnson & Vaughn, 2016; Orton & Weick, 1990). This might shed light on why intervention providers who were not employed by the DVA organisation may not have prioritised or fully understood the processes of evaluation data collection, due to having different organisational goals and practices. This may have had implications on how these stakeholders engaged in evaluation and invested in encouraging intervention recipients to engage in evaluation. In turn, this may provide invaluable insights regarding the limited evaluation data available in Study 1.

Applying Weick's (1976) theoretical model to DVA interventions for children enables exploration and transparency about the range of ways in which organisational context can impact how interventions are delivered and how stakeholders understand outcomes. Having little understanding of these may subsequently hamper the development of the intervention evidence base for interventions targeted at children who have experienced DVA.

9.5 Strengths and limitations

In light of the limitations associated with Study 1, Study 2 explored the views of children, parents and intervention providers in their experience of DVA interventions for children and young people, of which there has been limited qualitative research in the literature. In comparison with the methods used in Study 1 for exploring the effectiveness of the interventions, the qualitative interviews enabled a much richer understanding of how children, parents and intervention providers experienced the interventions. The inclusion of these participant groups enabled important comparisons between their narratives and in particular facilitated an understanding of the lives in which the interventions were experienced. Bringing together the findings from both studies, this thesis also highlights the difficulties in analysing seemingly 'straightforward' outcome data collected for the purpose of evaluating intervention effectiveness.

The lessons learned from Study 1 and the unique insights from Study 2, all make important and well-timed contributions to this area of DVA research. The findings from this qualitative study provide important insights for the development of future trial based research (Woolfall et al., 2014). In particular this thesis draws attention to methodological and measurement issues relating to the evaluation of DVA interventions for children and young people. Identifying these methodological insights is especially timely as the evidence base for these interventions is currently inconclusive. This thesis identifies the importance of prioritising the voice of the child in service development as well as in understanding the relevance of indicators of effectiveness. Notwithstanding the contributions made by this project, there are a number of factors which limit the extent to which I was able to meet the aims of the study. The study aimed to i) examine the experiences of individuals who receive and deliver interventions targeted at children and young people who have experienced DVA; and, ii) identify the difficulties of demonstrating the effectiveness of interventions targeted at children and young people

who have experienced DVA. The limitations have implications on the knowledge claims made from this thesis of which will be discussed in this section.

The study is based on the experiences of people participating in one DVA organisation. This restricts the application of findings to one DVA organisation at one given point in time. While the study raises some general issues about the conduct of research in DVA interventions, it does not purport to reflect all DVA interventions. The implications of the findings discussed in Section 9.6 need to be considered in light of the highly contextualised nature of the study.

Although the qualitative interviews in Study 2 were in-depth and conducted longitudinally, a large proportion of potentially eligible participants did not participate in this research, as highlighted in Chapter 4. Difficulties with engaging participants and the limitations of time, meant that the study only explored intervention providers' and recipients' experiences in relation to specific cohorts of children who had attended an intervention. The study did not draw more widely on other cohorts of children and parents who had been involved in the intervention. The inclusion of a broader sample of intervention recipients would have strengthened the findings and resulted in a greater understanding of the experiences of the interventions. Whilst intervention providers as a participant group comprised a range of individuals in relation to their roles and responsibilities, qualifications, and experiences, a broader group of eligible intervention providers such as local commissioners could have been invited to participate. In light of the limited sample, this challenges the extent to which the aims of the study have been fully met.

Throughout this thesis I have emphasised the value and importance of accessing children's voices in DVA intervention research. However, I acknowledge that only the voices of three children have been presented in this thesis. This is a very small sample. While it must be acknowledged that there are difficulties accessing the voice of the child, particularly in areas of sensitivity, a larger sample would have enabled a greater understanding of the DVA intervention to emerge. The type of information received from this small sample of children was revealing and highlights the importance of their accounts in understanding any type of intervention or service. The children in this study were recruited through their parents, which meant that not all eligible children had the opportunity to be invited to participate. This raises questions about how the balance between the child's rights to participate in research can be balanced by the need to ensure their protection from coercion. With hindsight, I might have placed greater focus in Studies 1 and 2 on prioritising children's voices in a role other than study

participation. For instance, I could have invited a group of children to be involved in the research as PPI contributors, discussing and advising on the design and implementation of the research from its conception, and providing feedback on the intended methods of participant recruitment and data collection. In addition, the involvement of adult stakeholders as PPI contributors was also absent from Studies 1 and 2 and their inclusion may have surmounted some of the difficulties experienced in conducting the research. For example, parents' views about their role in initiating a conversation with their child about a research opportunity could have been explored.

As discussed in Chapter 4, there were a number of ways in which I aimed to manage quality assurance across the research process of Study 2. However, one key aspect that could have been given more attention was respondent validation. Whilst I sought respondent validation with all participant groups throughout data collection, I talked about my findings and analysis to a few select audiences, including a small number of intervention providers. Although all the intervention providers were invited to attend the presentation I did not invite children and parents or provide them with an opportunity to receive feedback about the research. This was a deliberate strategy arising from a desire to avoid contacting them a considerable period after their involvement in the research. However, had there been PPI contributors in this study, I may have approached this aspect of quality assurance differently and adopted strategies which would have enabled my findings to be discussed more widely.

Another limitation of the study is that there are some aspects of the qualitative themes which could have teased out the interplay between the different participants in this study. This may have been ameliorated by engaging more sufficiently in the quality assurance of the study, by adopting further strategies to ensure triangulation of the data and being more reflexive in relation to the data that was collected. For example, in Chapter 7, there was little interplay between voices in Theme 5, as there was heavy emphasis on the voices of intervention providers. In this instance, I did not directly ask children and parents to share their views about barriers to intervention evaluations, but with hindsight I could have invited them to present their perspectives. Furthermore, there could have been greater interplay between the multiple voices in relation to Theme 6. In this instance, the interplay of voices between children and mothers was presented, whilst intervention providers' perspectives about the role of qualitative methods to explore intervention outcomes could have been drawn upon. I could have given greater attention to the interplay between the multiple voices had I engaged more reflexively throughout data collection and analysis, and sought to better engage with triangulating

data from the participant groups. This may have enabled a more comprehensive understanding about intervention recipients' and providers' views about barriers to intervention evaluation and the contribution of qualitative methods.

In summary, the research went some way to meeting the study aims but was not entirely successful. This limits the extent to which the knowledge claims and implications arising from this thesis can be applied more widely than the context within which they were generated.

9.6 Implications

Based on the findings from this thesis, there are implications to consider in light of theory, practice, policy and research. This section discusses these implications in relation to each of these areas.

9.6.1 Implications for theory

Chapter 1 introduced theoretical discussions regarding how children who have experienced DVA are often positioned as damaged, passive witnesses and 'caught' in the intergenerational transmission of violence. The findings from this thesis contribute to contextualising these theoretical discussions by considering how an intervention is perceived in the life of a child and which children are in most need of it. Not only can interventions be seen as a solution to preventing the intergenerational transmission of violence but they can be viewed as resolving difficulties that parents feel unequipped to address, particularly amongst children who demonstrate behaviours that are inconsistent with a normative childhood. How interventions are perceived by adults and how interventions are communicated to children can further position children as passive beings who are changed by an intervention, especially when children are uncertain as to the purpose of an intervention. Continuing to view children as damaged in the context of DVA and in need of an intervention may lead to further reinforcing the perception that an intervention can fix a child and risks overlooking their paradoxical resilience strategies (Alexander et al., 2016). These contributions can also be made in relation to those children and young people who have not necessarily experienced DVA, as the way in which children are perceived in light of their life experiences can locate how interventions are viewed and constructed. It is these constructions about children and interventions that can undermine children's agency and the value of their voice.

9.6.2 Implications for policy

Children and young people's access to service provision and their participation in service development and evaluation can be heavily shaped by how children and young people are represented and positioned in policy frameworks. As discussed in Chapter 1, the limited recognition of children and young people being directly affected by DVA in policy, has led to services for them being framed as 'bolt on' services to those of adults (Callaghan et al., 2018a). Subsequently, the contribution of children and young people in service development and evaluation has taken low priority in DVA intervention research. As children and young people's participation in collective decision making is interlinked with how they are seen and perceived (Tisdall, 2017), it is recommended that making changes to current legislation by recognising children's direct experiences of DVA and embedding the voice of the child in policy should prompt individuals working with this population of children to listen and respond to their voices. This requires political will and investment in opportunities for children to communicate their views by positioning them as experts in their own lives, and valuing their experiences and contributions (Lundy, 2007). Thus, the influence of policy in shaping how all children are represented is critical to consider, and specifically, the implications this has for understanding, developing and evaluating DVA interventions should not be undermined.

9.6.3 Implications for practice

As has been discussed, the value of the voice of the child is paramount to developing and evaluating interventions. Obscuring the voice of the child may communicate to children that their voices are not valued and may prevent children from making important contributions to developing, implementing and evaluating services available to them (Carlberg, Thorén, Billström, & Odhammar, 2009; Day, Carey, & Surgenor, 2006; Dew & Bickman, 2005). It is therefore recommended that the voice of the child is prioritised not just in the context of DVA, but in any organisation that provides services for children. Consideration needs to be given to the ways in which the rights of the child are embedded in all children's services. By prioritising both children's right to protection and right to participation, the voice of the child can make invaluable contributions to the way in which interventions are made accessible to them. If children have a clear understanding about the intervention which they are about to participate it is possible that the benefits of participation could be augmented, since this understanding does not need to evolve over the course of the intervention. However, it is possible that achieving this understanding is not simply a matter of telling the child but allowing the understanding to emerge over time. This may bring to question the length of

interventions for children, and the extent to which it is expected that children are fully aware about the experiences they have had. The voice of the child is also critical in the development and evaluation of services and interventions. In the context of interventions targeted at children who have experienced DVA, this should involve children in the development of COS, informing what methods and tools could be used to evaluate outcomes, as well as having an active involvement in intervention development and even the recruitment and training processes of intervention facilitators. Furthermore, it should be questioned as to what role children have in contributing to the initiative to prevent DVA, whereby they are given the opportunities to initiate campaigns and interventions that aim to raise awareness about DVA, and to promote healthy relationships in ways that build upon the existing strengths of children and young people. Thus, developing a culture of embedding children's rights across all matters that concern them is critical to ensuring their contribution to developing a better world.

As experienced in this doctoral thesis, identifying divergent views amongst interventions stakeholders is paramount as these divergences can impact how interventions are understood in relation to children and young people, how individuals engage with interventions and how intervention effectiveness is perceived and reported. It is important that an intervention is set up to communicate consistent and clear messages to intervention providers and recipients about the role of an intervention and expectations of intervention engagement. Ensuring that clear and consistent messages about the purpose of an intervention and parents' role in supporting their children is also important to establish. For example, if parent sessions are viewed as a fundamental part of supporting their child, then having measures in place that ensure parents 'sign up' to parent sessions or setting them up to be compulsory and more frequent, rather than being 'optional' and irregular could make a significant difference to how they are perceived. Therefore, it should be identified whether there are divergent views and why, clarifying divergences before an intervention begins, as well as consistently reviewing these assumptions throughout the course of an intervention. It would also be beneficial for providers to engage in individual and team reflexive practice as they respond to feedback about how an intervention is experienced by children and parents. Inevitably there will be a range of views about how interventions are experienced but engaging in reflexive practice would enable intervention providers to be mindful of the best way to deliver an intervention for each cohort, whilst maintaining intervention integrity.

It is recommended that interventions should be set up to recognise and emphasise children's existing ways of coping in adversity rather than aiming to restore

normative childhood. Professionals who deliver these interventions should be trained in recognising children's agentic strategies (Callaghan, Alexander & Fellin, 2017c), as well as other stakeholders who commission or make referrals to these interventions, so that children are consistently supported in ways that recognise their agency. Reshaping assumptions about interventions for children and young people will inevitably have implications for how services are allocated to children. It should be considered how intervention-related factors such as its length and the evaluation outcomes measured, may miscommunicate assumptions about the purpose of an intervention and whether children are expected to undertake a passive or active role. If interventions are short in length and are recognised as being a small part of a child's life, it must be questioned what can be realistically achieved from short-term interventions and what types of other support services are available. Although this thesis did not seek to establish a consensus about what outcomes to measure, Chapter 2 identified that interventions for this population of children tend to measure a narrow set of health-oriented outcomes, and symptom reduction is the main currency of intervention effectiveness (Howarth et al., 2016). In light of how an intervention may be perceived, it should be carefully considered as to whether intervention outcomes communicate and reinforce certain messages about the purpose of interventions to stakeholders, in relation to this population of children and young people.

From the findings of the study, it is recognised that understanding the organisational context in which an intervention is situated is critical for ensuring sustainable and effective practices in intervention delivery and intervention evaluation processes. Ensuring organisational transparency would facilitate identifying where joint-working and communication could be improved. This is particularly important when there are gaps in the fulfilment of responsibilities that require additional resources for their sustainment, when intervention providers have little faith in evaluation tools, and when individuals involved in delivering and coordinating an intervention are not employed by different organisations. Applying Weick's (1976) framework of organisational structure provides an insightful contribution to identifying what structure is modelled by an organisation in the context of DVA interventions. Identifying this structure would contextualise the arising implications of delivering a service and provide direction as to how a structure may need to change in light of its impact on service provision and intervention evaluation. Whilst this is an area that requires further work in the context of DVA organisations, perhaps adopting a mixed model of both tight and loose coupling would be appropriate. This would enable an organisation to be flexible in

intervention delivery whilst maintaining intervention integrity. This would be especially important if interventions are delivered in multiple locations by different groups of facilitators. In light of ensuring that there is little decoupling, it is recommended that intervention providers sign up to their role in evaluation in order to demonstrate their commitment to robustly collecting intervention evaluation data.

The complexities of demonstrating intervention effectiveness raises important questions about what funding is available to support intervention evaluation, especially for organisations that depend on demonstrating intervention effectiveness to ensure their existence. It is especially important that organisations are supported in the evaluation data management process and can embed these practices into organisational practices, such that evaluation and routine data can be more easily located. It is also paramount to identify barriers to engaging with evaluation from both an intervention recipient and provider viewpoint. Furthermore, if existing outcome measures are believed to be inadequate and limited, these should be identified and reviewed. One of the key questions concerning these implications is with whom this responsibility sits, in order to ensure the robust evaluation of interventions, decide which tools are appropriate to measure, and account for contextual factors that may impact measured, unanticipated or adverse outcomes. This responsibility may be located with DVA organisations and voluntary services, commissioners, intervention developers, researchers or a combination of these groups working in collaboration. If it does involve collaborative working, then there would be value in using a concordat whereby a set of principles and mutual agreement amongst stakeholders can guide the conduct of the evaluation (Brewster et al., 2015). This would help to set expectations, ensure clear communication and resolve conflicts that may arise during intervention evaluation.

9.6.4 Implications for future research

Based on the lessons learned and findings from this thesis, it is recommended that future research should consider and prioritise four important areas when conducting research in relation to DVA interventions for children and young people. It is proposed that prioritising these areas in future research will be invaluable for developing the evidence base for interventions targeted at children and young people who have experienced DVA.

9.6.4.1 Prioritising the voice of the child

As discussed throughout this thesis, the familiar discourse of positioning children as damaged and silenced can lead to obscuring children's voices. This raises important questions concerning children being prevented from receiving the invitation to

participate in research (Øverlien & Holt, 2017). This thesis advocates the utmost importance of protecting the child, whilst ensuring their right to participation, so that children have the opportunity to make contributions to inform policy, service development and evaluation. However, this requires us to go beyond ‘hearing’ the voices of children, but to value the voices of children, positioning them as experts of their own lives. Future research should seek to prioritise and empower the voice of the child, particularly in relation to understanding their experiences of interventions, their contribution to developing new interventions and their participation as PPI contributors to inform the methods and outcomes used to measure intervention effectiveness. One example in the DVA literature which demonstrates not only that the voice of a child should be heard, but rather, valued and prioritised in how an intervention is developed and evaluated is the two-year European research project, UNARS (Understanding Agency and Resistance Strategies; Callaghan & Alexander, 2015). This project developed a group-based therapeutic intervention for children and young people who had experienced DVA and was informed by interviews with 107 children and young people in Greece, Italy, Spain and the UK, which focused on children’s experiencing of coping, resilience and agency. The voices of the children and young people were critical to developing an intervention that aimed to build on their existing strategies of coping, rather than viewing children as lacking in appropriate strategies. Children and young people across the four countries also contributed to completing quantitative outcome measures and participated in interviews about their experience of the intervention. Thus, the value of the voice of the child should be prioritised in research that aims to inform intervention development and the evaluation of services for them, whilst prioritising their right to protection from exploitation.

9.6.4.2 Consult with a range of intervention stakeholders

As this thesis has shown, intervention stakeholders even in a small scale study can have diverging views about the same intervention provided by one organisation. However, such views can have unintentional yet significant implications on how individuals engage with an intervention and view intervention effectiveness. It is important for future research to develop a culture of consulting with a broad selection of stakeholders, such as children, parents, service providers, commissioners, and teachers is important. Doing so may facilitate the identification of similarities and differences in stakeholder perspectives and how these differences may impact how interventions are experienced and reported in intervention evaluations. Moreover, investing in the consultation of a wide range of stakeholders would help to contextualise what outcomes

are meaningful for children who have experienced DVA and how outcomes might be perceived differently amongst stakeholders. Future research should seek to develop a culture of collaboration between stakeholder groups, prioritising more collaborative working to supporting children who have experienced DVA (Hester, 2011). As recognised in Chapter 3 and in Section 9.5 of this chapter, researchers should pursue the following research areas and consult PPI contributors in the planning and implementation of these:

1) Examining intervention stakeholders' perceptions of an intervention

From the findings of this thesis, it is recommended that future research builds on this work by exploring in greater depth the types of assumptions that underpin and shape how individuals understand interventions and observing similarities and differences held within and between stakeholder groups. This could involve exploring the views of children or parents who anticipate attending an intervention, those who are attending an intervention or have 'dropped out', and those who have previously attended. This would highlight the extent to which viewpoints differ in relation to the same intervention and identify what factors have contributed to such variability in order to reconcile these viewpoints. Future research should also explore the extent to which stakeholders recognise children's agency and whether interventions are set up to building upon children's existing ways of coping. Furthermore, research could explore what stakeholders perceive as being critical components of an intervention, with the view that this could meaningfully inform the design and development of interventions.

2) Exploring the experiences of intervention stakeholders in engaging with intervention evaluations

In order to encourage engagement in evaluation amongst a range of stakeholders, factors that may facilitate or hinder engagement need to be identified and responded to. This could be explored by researchers inviting a range of interventions stakeholders of interventions targeted at children who have experienced DVA to contribute to the design and implementation of evaluation studies. This could also involve providing stakeholders' feedback of existing and anticipated barriers and facilitators to engaging in intervention evaluation. Examining the views of stakeholders in relation to DVA perpetrator programmes as well as non-DVA related interventions may also provide important contributions when exploring this.

3) Developing a COS for interventions targeted at children who have experienced DVA

At present there is no consensus regarding what outcomes should be measured in relation to interventions for children who have experienced DVA and how these should be measured. This creates difficulties in establishing a robust evidence base of interventions for this population. Future research should begin to identify and understand what outcomes are important to a range of key intervention stakeholders, including children who have experienced DVA, and to identify meaningful outcomes that go beyond the narrow set of ‘symptom reduction’ outcomes that has been identified as commonplace across intervention evaluation studies (Howarth et al., 2016). Consulting with stakeholders would also be invaluable for overseeing the development and dissemination of a COS (Young & Bagley, 2016). Establishing a COS for children who have experienced DVA is not only important for developing the evidence base of interventions for children, but for facilitating the robust evaluation of interventions targeted at other family members (such as DVA perpetrators). The evaluation of these interventions may be examined in relation to measuring a consensus of outcomes for children (McConnell et al., 2017). In order to ensure minimal burden to those providing evaluation data and to encourage researchers to use a COS, the number of outcomes measured requires careful consideration (Young & Bagley, 2016), in addition to whether outcomes are measured in the short, intermediate and long-term and what time-frame constitutes each of these. When establishing key outcomes across a range of interventions for this population, this needs to address how COS can account for intervention theories of change. Furthermore, the resources that are needed to develop and implement a COS in the context of evaluation studies should not be overlooked (Gargon, Williamson, & Young, 2017).

9.6.4.3 Developing an intervention taxonomy of complexity

Howarth et al. (2016) recommended that implementing new interventions for children who have experienced DVA should be halted until a review of the existing interventions delivered in the UK has been undertaken. On the basis of the findings from this thesis and in light of Howarth et al.’s (2016) recommendation, it is proposed that establishing a knowledge bank of interventions requires the development of two types of taxonomy. The first taxonomy should seek to provide clear descriptions of the interventions to ensure consistency in distinguishing between intervention types and having standardised vocabulary that clearly defines intervention components and characteristics (Abraham & Michie, 2008). The second should seek to develop a

taxonomy of complexity (Wells et al., 2012) by specifying the context in which these interventions are delivered, such as organisational context, the setting and location of where interventions are delivered, and who delivers the interventions. This would facilitate an understanding of the landscape in which interventions are delivered and would help to identify what contextual factors may potentially impact intervention effectiveness.

One of the key contributions of this thesis is the application of Weick's (1976) framework of organisational structure in the context of delivering DVA interventions. In light of this, it is recommended that future research explores the impact of organisational structures on delivering, developing and evaluating interventions for children and young people who have experienced DVA, as this could make invaluable contributions to developing the taxonomy of complexity. Future research could examine the organisational context and structure in which an intervention is situated, in order to identify barriers to joint-working, intervention delivery, intervention integrity and evaluation. This may bring to light how organisational structures might be hampering the intervention evidence base, thus providing an opportunity for changes in organisational structures in order to ensure a robust evidence base. Examining the extent to which an organisation is tightly or loosely coupled may also provide insight regarding what implications an organisational structure has and this could be explored by conducting qualitative interviews, of which have been conducted in police and probation settings (Alarid et al., 2011).

9.6.4.4 Discussing the methodological challenges of conducting evaluation research

As discussed in Chapters 3 and 4, there were methodological challenges when conducting this doctoral research. However, bringing these difficulties to the forefront will be invaluable for future DVA research (Fraga, 2016). As reviewed in Chapter 2, studies that have sought to demonstrate intervention effectiveness of interventions targeted at children and young people who have experienced DVA often had weak methodological designs. Whilst the design of studies could be improved, this does not eliminate the practical challenges of conducting intervention evaluation research in practice. Thus, it would be beneficial for these challenges to be documented to inform other researchers. The challenges I experienced with inconsistent and limited evaluation data as discussed in Chapter 3, and those discussed in Chapter 4 which included difficulties in conducting follow-up interviews, and logistical limitations of participant recruitment, are all important to document for future research. Where possible these

discussions should be embedded into studies that explore experiences or outcomes of DVA interventions. Identifying these challenges would not only contextualise some of the limitations of a study, but they could also provide invaluable methodological contributions for researchers by sharing how challenges were responded to, especially when seeking to prioritise the voices of children. This may help researchers to have realistic expectations about what research difficulties can be faced and what strategies may be helpful in addressing these. When I approached parents and the DVA service about the child's invitation to participate in the research for this thesis, I did not encounter the resistance that I had anticipated. There are a number of possible reasons for why this was the case. Firstly, parents and intervention providers had already signed up and participated in the research and were informed about the purposes of the research. Secondly, I had established a high level of trust and familiarity through the longevity of my relationships with adult participants, particularly as they were often interviewed on more than one occasion. Thirdly, as the interviews were conducted in the family home, as I got to know the parents, the parents in this study facilitated the children's participation, by for example, making extra efforts to ensure that other family members would not disturb the child's interview. Thus, engaging in discussions such as these will be invaluable for identifying where progress has been made in the field, and where methodological challenges remain.

9.7 Conclusion

It would seem contradictory to deliver any intervention without having a clear understanding about its effectiveness, how it worked and the views of those receiving and delivering it. Although the field of DVA has only in recent years been discussed more openly in the public sphere, the effectiveness of interventions for children who have experienced DVA remains relatively underexplored. Whilst this might shed some light on why the evidence base is embryonic, this thesis has aimed to unpick further the context in which evidencing intervention effectiveness is difficult and complex.

Importantly, this thesis argues that the voice of the child is paramount and the voices of children and young people need to be listened and responded to, rather than silenced. However, the way in which children and young people are positioned and represented in policy frameworks can have implications for their involvement in research and intervention evaluation. By prioritising children's right to protection from harm and their right to participation, they can be understood as experts of their own lives who can make invaluable contributions to the development of policy and practice if

given the opportunity. However, this requires a shift in how we view children and young people's responses in their experiences of adversity, whereby we recognise their agency and their existing ways of coping, rather than viewing an intervention as a solution to fixing them. In turn, the support provided to them should build upon their existing strengths. It is important to establish this change in attitude, so that we no longer construct children and young people as a problem, warranting a solution, based on idealised assumptions of what constitutes normative childhood. As a result, this should impact how individuals locate an intervention in the life of a child, how parents choose to engage with and intervention, and impact how intervention outcomes are understood and reported.

This thesis has also advocated the importance of consulting with a range of stakeholders when developing and evaluating interventions for children and young people. The voices of adult stakeholders should not be limited to outcome reporting alone but rather, it is fundamental to capture a range of views about an intervention in order to identify divergent views which may impact how an intervention is engaged with. Establishing an appreciation for different views is critical in order to better understand how these views have been formed and how consistent messages can be more clearly communicated.

The commitment of organisations working to support children and young people who have experienced DVA should not be understated. It is by examining how these organisations work, and work with others particularly when resources are few, that we begin to appreciate the realities of supporting this group of young people. The organisational context in which interventions are situated requires joint-working within and across organisations in order to support children who have experienced DVA and to deliver and evidence interventions robustly. However, as the HM Government's recent consultation, 'Transforming the response of Domestic Abuse' (2018) has advocated for more collaborative working, it becomes more pressing that we seek to understand how organisations work together, particularly in order to deliver interventions that maintain programme integrity and robustly demonstrate intervention effectiveness.

Whilst this thesis initially aimed to demonstrate the effectiveness of interventions for children and young people who experienced DVA, Study 1 provided important lessons to be learned from and shaped how the thesis evolved. Over time it became increasingly apparent that it was critical to examine the experiences of those receiving and delivering an intervention. As a result, this thesis makes a significant contribution to identifying the challenges of developing a robust evidence base for

children who have experienced DVA in order to find ways of improving and developing the evidence base. However, prioritising the voices of children and young people not only so that they no longer remain silenced, but rather, have the opportunity to actively make a positive difference in this world must be central to the design, implementation, dissemination, and evaluation of interventions wherever they take place.

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APPENDICES

Appendix 1: Study 1- Ethical approval confirmation, participant information sheets and consent forms, and letters to teachers

Ethical approval confirmation of Study 1



Ethics
Thu 28/08/2014, 08:18
Alison, Laurence; McGuire, Grace <Grace.Carter@liverpool.ac.uk>; Giles, Susan [spgiles] ✉

Replied

Dear all,

I am pleased to inform you that the Sub-Committee has approved your application for ethical approval for your study. Details and conditions of the approval can be found below.

Ref: RETH000749
Sub-Committee: Non-Invasive Procedures
Review type: Full committee review
Principle Investigator: Professor Laurence Allison
Student Investigator: Miss Grace McGuire
School: Psychology
Title: Evidence based solutions to reducing domestic violence- examining outcome measures and impact of whole family service interventions
First Reviewer: Dr Mark O'Brien
Date of initial review: 22/07/14
Date of Approval: 28/08/14

The application was APPROVED subject to the following conditions:

Conditions

All serious adverse events must be reported to the Sub-Committee within 24 hours of their occurrence, via the Research Integrity and Governance Officer (ethics@liv.ac.uk).

This approval applies for the duration of the research. If it is proposed to extend the duration of the study as specified in the application form, the Sub-Committee should be notified. If it is proposed to make an amendment to the research, you should notify the Sub-Committee by following the Notice of Amendment procedure outlined at <http://www.liv.ac.uk/media/livacuk/researchethics/notice%20of%20amendment.doc>. If the named PI / Supervisor leaves the employment of the University during the course of the approval, the approval will lapse. Therefore please contact the Research Integrity and Governance Officer at ethics@liverpool.ac.uk in order to notify them of a change in PI / Supervisor.

Kind regards,

Matthew

Matthew Billington
Research Integrity and Governance Officer

Research Support Office
University of Liverpool
Waterhouse Building (2nd Floor, Block C)
3 Brownlow Street

Participant information sheet- (for parents)

Research project: Evidence based solutions to reducing domestic violence- examining outcome measures and impact of whole family service interventions

You are being invited to participate in a research study. Before you decide whether to participate, it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and feel free to ask us if you would like more information or if there is anything that you do not understand. Please also feel free to discuss this with your friends, relatives and GP if you wish. We would like to stress that you do not have to accept this invitation and should only agree to take part if you want to.

1. What is the purpose of the study?

This study will examine the impact that a child/young person's participation in an intervention programme (XXXX, XXXX or XXXX) run by XXXX has on their school attendance, performance, and behaviour.

2. Why have I been invited to take part?

We feel it important to gain your consent for a school teacher to provide us with feedback about the impact the intervention programme is having on your child in school (1 month before and 6 months after they participate on a programme), so we can evaluate how effective the programme is. We would also like to gain your consent for a teacher also sharing this information should it be that your child does not complete the programme.

3. Do I have to take part?

No, your participation in providing consent is completely voluntary. You are also free to withdraw at any time should you decide that you no longer wish to take part.

4. What will happen if I take part?

Firstly, we would like to ask for your consent for us to ask a member of staff from your child's school about the impact of the intervention before and after your child takes part in a programme, on their school attendance and behaviour at school. We ask that you sign the consent form attached and provide the name of a teacher that we can contact. Once we have contacted the named teacher, they will have the option of whether they wish to participate. The information provided by the teacher will be recorded anonymously so that your child will not be identifiable, and this information is only requested for the purposes of evaluating the impact of the intervention programme.

5. Are there any benefits to taking part?

It is hoped that by your provision of consent for school teachers to provide feedback on how the intervention programme, and should they wish to participate, this will enable us to provide XXXX with important recommendations for improving their service and to see what impact their intervention programmes can have.

6. Will my participation be kept confidential?

All data attained from the study is for research purposes only. You, your child, and school teachers will not be personally identifiable from reports that are written as a result of the data collection.

7. Are there any risks in taking part?

There are no physical risks to you should you take part. However, any safeguarding disclosures made by school staff that requires statutory action will be reported to XXXX for the purpose of safeguarding children.

8. What should I do if I have any questions?

Please feel free to let us know by contacting the Principal Investigator, Professor Laurence Alison via e-mail at l.j.alison@liverpool.ac.uk and we will try to help. If you have a complaint which you feel you cannot come to us with then you should contact the Research Governance Officer at ethics@liv.ac.uk. When contacting the Research Governance Officer, please provide details of the name or description of the study (so that it can be identified), the researcher(s) involved, and the details of the complaint you wish to make.

If you have any further queries about taking part in this research or questions about the aims of the research in general, please do not hesitate to contact the Principal Investigator.

Thank you for taking the time to read this information sheet. If you would like to take part in this research then please read and sign the attached consent form.



Committee on Research Ethics

PARTICIPANT CONSENT FORM (for parents)

Title of Research Project: Evidence based solutions to reducing domestic violence- examining outcome measures and impact of whole family service interventions

Researcher(s): Professor Laurence Alison and Grace McGuire

Please
initial
box

- | | |
|--|--------------------------|
| 1. I confirm that I have read and have understood the information sheet dated 14 th Aug 2014 for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. | <input type="checkbox"/> |
| 2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my rights being affected. | <input type="checkbox"/> |
| 3. I understand that, under the Data Protection Act, I can at any time ask for access to the information I provide and I can also request the destruction of that information if I wish. | <input type="checkbox"/> |
| 4. I understand that confidentiality and anonymity will be maintained and it will not be possible to identify me in any publications. | <input type="checkbox"/> |
| 5. I give consent for the following school contact to provide the information requested to the researchers, for research purposes only: <i>name of teacher</i> | <input type="checkbox"/> |
| 6. I give consent for the named individual to provide the requested information should it be that my child does not complete the programme. | <input type="checkbox"/> |
| 7. I agree to take part in the above study | <input type="checkbox"/> |

Participant Name

Date

Signature

_____	_____	_____
Name of Person taking consent	Date	Signature
_____	_____	_____
Researcher	Date	Signature

Principal Investigator:

Name- Professor Laurence Alison
 Work Address- Eleanor Rathbone Building,
 Bedford Street South, Liverpool, L69 6ZA
 Work Email- l.j.alison@liverpool.ac.uk

Student Researcher:

Name- Grace McGuire
 Work Address- Eleanor Rathbone Building
 Bedford Street South, Liverpool, L69 6ZA
 Work Email- g.mcguire@liv.ac.uk

Participant information sheet- (for children and young people)

Research project: Evidence based solutions to reducing domestic violence- examining outcome measures and impact of whole family service interventions

You are being invited to participate in a research study. Before you decide whether to participate, it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and feel free to ask us if you would like more information or if there is anything that you do not understand. Please also feel free to discuss this with your friends, relatives and GP if you wish. We would like to stress that you do not have to accept this invitation and should only agree to take part if you want to.

1. What is the purpose of the study?

XXXX) provide 3 intervention programmes for children and young people: XXXX, XXXX, and XXXX. This study will examine what impact these programmes have for children and young people that participate on them.

2. Why have I been invited to take part?

You have been invited to take part because you are going to participate on one of these programmes and we would like your permission for us to see what effect the programmes have. We would like to see how the intervention programmes have affected your school performance and behaviour and how the programme has supported your parents.

3. Do I have to take part?

No, your participation in providing consent is completely voluntary. You are also free to withdraw at any time should you decide that you no longer wish to take part.

4. What will happen if I take part?

By providing your consent, we will be able to see what impact the intervention programme has this will be very helpful for programme facilitators. This will not affect the quality of the service that you receive.

5. Are there any benefits to taking part?

It is hoped that by your provision of consent, we will be able to provide important feedback to XXXX about the programmes they provide for the future.

6. Will my participation be kept confidential?

All data attained from the study is for research purposes only. You, your parents and school teachers will not be personally identifiable from reports that are written as a result of the data collection.

7. Are there any risks in taking part?

There are no physical risks to you should you take part. However, any safeguarding disclosures made by school staff or parents that requires statutory action will be reported to XXXX for the purpose of your safeguarding.

8. What should I do if I have any questions?

Please feel free to let us know by contacting the Principal Investigator, Professor Laurence Alison via e-mail at l.j.alison@liverpool.ac.uk and we will try to help. If you have a complaint which you feel you cannot come to us with then you should contact the Research Governance Officer at ethics@liv.ac.uk. When contacting the Research Governance Officer, please provide details of the name or description of the study (so that it can be identified), the researcher(s) involved, and the details of the complaint you wish to make.

If you have any further queries about taking part in this research or questions about the aims of the research in general, please do not hesitate to contact the Principal Investigator.

Thank you for taking the time to read this information sheet. If you would like to take part in this research then please read and sign the attached consent form.



Committee on Research Ethics

PARTICIPANT CONSENT FORM (for children and young people)

Title of Research Project: Evidence based solutions to reducing domestic violence- examining outcome measures and impact of whole family service interventions

Researcher(s): Professor Laurence Alison and Grace McGuire

**Please
initial box**

1. I confirm that I have read and have understood the information sheet dated 14th Aug 2014 for the above study. I have been able to ask questions and have had these questions answered ☐
2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my rights being affected. ☐
3. I understand that, under the Data Protection Act, I can at any time ask for access to the information I provide and I can also request the destruction of that information if I wish. ☐
4. I understand that confidentiality and anonymity will be maintained and it will not be possible to identify me in any publications. ☐
5. I understand that my parents and teachers may provide information that will help the researchers see what impact the intervention programme has, and I understand that this will not affect the quality of the service I receive. ☐
6. I agree to take part in the above study ☐

_____ Participant Name	_____ Date	_____ Signature
_____ Name of Person taking consent	_____ Date	_____ Signature
_____ Researcher	_____ Date	_____ Signature

Principal Investigator:

Name- Professor Laurence Alison
Work Address- Eleanor Rathbone Building,
Bedford Street South, Liverpool, L69 6ZA
Work Email- l.j.alison@liverpool.ac.uk

Student Researcher:

Name- Grace McGuire
Work Address- Eleanor Rathbone Building
Bedford Street South, Liverpool, L69 6ZA
Work Email- g.mcguire@liv.ac.uk

Version 2: 14th Aug 2014



Grace McGuire MBPsS, B.Sc (Hons), M.Sc
PhD Researcher in Forensic and Investigative Psychology
Department of Psychological Sciences
University of Liverpool
Eleanor Rathbone Building (Room 2.58)
Bedford Street South
Liverpool
L69 7ZA
g.mcguire@liverpool.ac.uk

[SCHOOL ADDRESS]

[DATE]

Dear

One of your students [NAME] is attending [INTERVENTION]

The University of Liverpool are conducting an external evaluation of the [INTERVENTION]. An important part of this evaluation involves monitoring the impact of the programme in school. We have informed the student and their parents about this research and they have provided us with your details and their consent for to us to contact you and provide the information that is central to this research study.

We would like to ask if you could kindly take the time to complete the enclosed questionnaire and return in the stamped addressed envelope enclosed. The purpose of this information is for monitoring and evaluation measures pre and post group over a period of time. We will be asking you to complete a questionnaire to account for these measures since the beginning of the academic year, 1 month and 6 months after the programme has been completed by the student. Enclosed is the questionnaire, an information sheet which provides further details about the nature of this research and a consent form for you to complete confirming that you wish to provide this information. It would be gratefully appreciated if you could return the questionnaire and consent form to me as soon as possible.

Please do not hesitate to contact me if you have any further questions, and I look forward to hearing from you soon.

Yours faithfully,

Grace McGuire (Researcher)



Grace McGuire MBPsS, B.Sc (Hons), M.Sc

PhD Researcher in Forensic and Investigative Psychology

Department of Psychological Sciences

University of Liverpool

Eleanor Rathbone Building (Room 2.58)

Bedford Street South

Liverpool

L69 7ZA

g.mcguire@liverpool.ac.uk

[SCHOOL ADDRESS]

[DATE]

Dear

Thank you very much completing the first questionnaire to me for [STUDENT]

As [STUDENT] recently completed [INTERVENTION] it would be much appreciated if you could complete the follow- up questionnaire which will assess behaviour 1 month [OR 6 MONTHS] post-intervention. You will note that the questionnaire is identical to the earlier questionnaire you completed. We have also attached a page for you to share any additional comments. It would be greatly appreciated if you could take the time to complete the enclosed documents and return in the stamped addressed envelope enclosed.

Please do not hesitate to contact me if you have any further questions, and I look forward to hearing from you soon. Thank you again for your participation.

Yours faithfully,

Miss Grace McGuire (Researcher)

Participant information sheet (for teachers)

Research project: Evidence based solutions to reducing domestic violence- examining outcome measures and impact of whole family service interventions

You are being invited to participate in a research study. Before you decide whether to participate, it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and feel free to ask us if you would like more information or if there is anything that you do not understand. We would like to stress that you do not have to accept this invitation and should only agree to take part if you want to.

1. What is the purpose of the study?

This study will aim to examine the longitudinal education outcomes of children who are participating in an intervention programme (either, XXXX, XXXX or XXXX) run by XXXX. Researchers from the University of Liverpool will be examining education measures before children engage in an intervention programme and at various time points after engaging with it.

2. Why have I been invited to take part?

You have been invited to take part as child and parental consent has been given for you to provide information in order to evaluate the outcomes of an intervention programme.

3. Do I have to take part?

No, your participation is completely voluntary. You are also free to withdraw at any time should you decide that you no longer wish to take part.

4. What will happen if I take part?

You are invited to complete a questionnaire. Questions will be asked about the child in relation to a certain time frame regarding the following education outcomes: number of absences from school, behavioural incidents and academic achievement, and strength and difficulties questionnaire (which is attached). The answers will be recorded on an electronic data file which will be anonymised. You will be contacted in after the intervention has ended, with the opportunity to complete further questionnaires 1 and 6 months post-intervention.

5. Will my participation be kept confidential?

It is possible that you may make disclosure of serious criminal activity. Therefore, confidentiality may not always be assured. However, for the purposes of this research, you will not be personally identifiable from reports that are written as a result of the data collection. In the event that sensitive information is disclosed which requires safeguarding action, you be will be informed of the need to disclose and the research interview will be suspended. The issue will then be reported to XXXX staff who will manage any safeguarding responsibilities. Should sensitive issues be raised which require further support or follow-up, participants will be informed of agencies that will be able to provide them with further support and guidance and they will be offered follow up support by XXXX

6. Are there any risks in taking part?

There are no physical risks to you should you take part. Any disclosures that are made which require statutory or safeguarding action will be reported to XXXX for the purpose of safeguarding children.

7. What if I am unhappy or if there is a problem?

If you are unhappy, or if there is a problem, please feel free to let us know by contacting the Principal Investigator, Professor Laurence Alison via e-mail at l.j.alison@liverpool.ac.uk and we will try to help. If you remain unhappy or have a complaint which you feel you cannot come to us with then you should contact the Research Governance Officer at ethics@liv.ac.uk. When contacting the Research Governance Officer, please provide details of the name or description of the study (so that it can be identified), the researcher(s) involved, and the details of the complaint you wish to make.

8. What should I do if I have any more questions?

If you have any further queries about taking part in this research or questions about the aims of the research in general, please do not hesitate to contact the Principal Investigator.

Thank you for taking the time to read this information sheet. If you would like to participate, please read and sign the attached consent form, and complete the questionnaire, and post them to the researchers using the self-addressed stamped envelope.

Committee on Research Ethics

PARTICIPANT CONSENT FORM- (for teachers)

Title of Research Project: Evidence based solutions to reducing domestic violence- examining outcome measures and impact of whole family service interventions

Researcher(s): Professor Laurence Alison and Grace McGuire

**Please initial
box**

1. I confirm that I have read and have understood the information sheet dated 14th Aug 2014 for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. ☐
2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my rights being affected. In addition, should I not wish to answer any particular question or questions, I am free to decline. ☐
3. I understand that, under the Data Protection Act, I can at any time ask for access to the information I provide and I can also request the destruction of that information if I wish. ☐
4. I understand that confidentiality and anonymity will be maintained and it will not be possible to identify me in any publications. ☐
5. I agree to take part in the above study ☐

Participant Name

Date

Signature

Name of Person taking consent

Date

Signature

Researcher

Date

Signature

Principal Investigator:

Name- Professor Laurence Alison
Work Address- Eleanor Rathbone Building,
Bedford Street South, Liverpool, L69 6ZA
Work Email- l.j.alison@liverpool.ac.uk
Version 2: 14th Aug 2014

Student Researcher:

Name- Grace McGuire
Work Address- Eleanor Rathbone Building
Bedford Street South, Liverpool, L69 6ZA
Work Email- g.mcguire@liv.ac.uk

Appendix 2: Strengths and Difficulties Questionnaires (child, parent and teacher questionnaires)

Self-completed SDQ (SDQ-S)

Strengths and Difficulties Questionnaire

S 11-17

For each item, please mark the box for Not True, Somewhat True or Certainly True. It would help us if you answered all items as best you can even if you are not absolutely certain or the item seems daft! Please give your answers on the basis of how things have been for you over the last six months.

Your Name

Male/Female

Date of Birth.....

	Not True	Somewhat True	Certainly True
I try to be nice to other people. I care about their feelings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I am restless, I cannot stay still for long	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I get a lot of headaches, stomach-aches or sickness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I usually share with others (food, games, pens etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I get very angry and often lose my temper	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I am usually on my own. I generally play alone or keep to myself	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I usually do as I am told	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I worry a lot	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I am helpful if someone is hurt, upset or feeling ill	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I am constantly fidgeting or squirming	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I have one good friend or more	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I fight a lot. I can make other people do what I want	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I am often unhappy, down-hearted or tearful	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other people my age generally like me	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I am easily distracted, I find it difficult to concentrate	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I am nervous in new situations. I easily lose confidence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I am kind to younger children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I am often accused of lying or cheating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other children or young people pick on me or bully me	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I often volunteer to help others (parents, teachers, children)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I think before I do things	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I take things that are not mine from home, school or elsewhere	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I get on better with adults than with people my own age	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I have many fears, I am easily scared	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I finish the work I'm doing. My attention is good	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Do you have any other comments or concerns?

Please turn over - there are a few more questions on the other side

Overall, do you think that you have difficulties in one or more of the following areas:
emotions, concentration, behaviour or being able to get on with other people?

No	Yes- minor difficulties	Yes- definite difficulties	Yes- severe difficulties
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If you have answered "Yes", please answer the following questions about these difficulties:

- How long have these difficulties been present?

Less than a month	1-5 months	6-12 months	Over a year
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

- Do the difficulties upset or distress you?

Not at all	Only a little	Quite a lot	A great deal
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

- Do the difficulties interfere with your everyday life in the following areas?

	Not at all	Only a little	Quite a lot	A great deal
HOME LIFE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
FRIENDSHIPS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
CLASSROOM LEARNING	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
LEISURE ACTIVITIES	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

- Do the difficulties make it harder for those around you (family, friends, teachers, etc.)?

Not at all	Only a little	Quite a lot	A great deal
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Your Signature

Today's Date

Thank you very much for your help

© Robert Goodman, 2005

Strengths and Difficulties Questionnaire

S11-17
FOLLOW-UP

For each item, please mark the box for Not True, Somewhat True or Certainly True. It would help us if you answered all items as best you can even if you are not absolutely certain or the item seems daft! Please give your answers on the basis of how things have been for you over the last month.

Your Name

Male/Female

Date of Birth.....

	Not True	Somewhat True	Certainly True
I try to be nice to other people. I care about their feelings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I am restless, I cannot stay still for long	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I get a lot of headaches, stomach-aches or sickness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I usually share with others (food, games, pens etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I get very angry and often lose my temper	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I am usually on my own. I generally play alone or keep to myself	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I usually do as I am told	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I worry a lot	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I am helpful if someone is hurt, upset or feeling ill	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I am constantly fidgeting or squirming	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I have one good friend or more	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I fight a lot. I can make other people do what I want	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I am often unhappy, down-hearted or tearful	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other people my age generally like me	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I am easily distracted, I find it difficult to concentrate	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I am nervous in new situations. I easily lose confidence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I am kind to younger children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I am often accused of lying or cheating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other children or young people pick on me or bully me	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I often volunteer to help others (parents, teachers, children)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I think before I do things	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I take things that are not mine from home, school or elsewhere	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I get on better with adults than with people my own age	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I have many fears, I am easily scared	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I finish the work I'm doing. My attention is good	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Do you have any other comments or concerns?

Please turn over - there are a few more questions on the other side

Since coming to the clinic, are your problems:

Much worse	A bit worse	About the same	A bit better	Much better
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Has coming to the clinic been helpful in other ways, e.g. providing information or making the problems more bearable?

Not at all	Only a little	Quite a lot	A great deal
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Over the last month, have you had difficulties in one or more of the following areas: emotions, concentration, behaviour or being able to get on with other people?

No	Yes-minor difficulties	Yes-definite difficulties	Yes-severe difficulties
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If you have answered "Yes", please answer the following questions about these difficulties:

- Do the difficulties upset or distress you?

Not at all	Only a little	Quite a lot	A great deal
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

- Do the difficulties interfere with your everyday life in the following areas?

	Not at all	Only a little	Quite a lot	A great deal
HOME LIFE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
FRIENDSHIPS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
CLASSROOM LEARNING	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
LEISURE ACTIVITIES	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

- Do your difficulties make it harder for those around you (family, friends, teachers etc.)?

Not at all	Only a little	Quite a lot	A great deal
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Your signature

Today's date

Thank you very much for your help

© Robert Goodman, 2005

Parent SDQ (SDQ-P)

Strengths and Difficulties Questionnaire

P 4-17

For each item, please mark the box for Not True, Somewhat True or Certainly True. It would help us if you answered all items as best you can even if you are not absolutely certain or the item seems daft! Please give your answers on the basis of the child's behaviour over the last six months.

Child's Name

Male/Female

Date of Birth.....

	Not True	Somewhat True	Certainly True
Considerate of other people's feelings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Restless, overactive, cannot stay still for long	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Often complains of headaches, stomach-aches or sickness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Shares readily with other children (treats, toys, pencils etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Often has temper tantrums or hot tempers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rather solitary, tends to play alone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Generally obedient, usually does what adults request	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Many worries, often seems worried	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Helpful if someone is hurt, upset or feeling ill	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Constantly fidgeting or squirming	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Has at least one good friend	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Often fights with other children or bullies them	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Often unhappy, down-hearted or tearful	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Generally liked by other children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Easily distracted, concentration wanders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nervous or clingy in new situations, easily loses confidence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kind to younger children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Often lies or cheats	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Picked on or bullied by other children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Often volunteers to help others (parents, teachers, other children)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thinks things out before acting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Steals from home, school or elsewhere	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gets on better with adults than with other children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Many fears, easily scared	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sees tasks through to the end, good attention span	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Do you have any other comments or concerns?

Please turn over - there are a few more questions on the other side

Overall, do you think that your child has difficulties in one or more of the following areas: emotions, concentration, behaviour or being able to get on with other people?

No	Yes-minor difficulties	Yes-definite difficulties	Yes-severe difficulties
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If you have answered "Yes", please answer the following questions about these difficulties:

- How long have these difficulties been present?

Less than a month	1-5 months	6-12 months	Over a year
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

- Do the difficulties upset or distress your child?

Not at all	Only a little	Quite a lot	A great deal
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

- Do the difficulties interfere with your child's everyday life in the following areas?

	Not at all	Only a little	Quite a lot	A great deal
HOME LIFE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
FRIENDSHIPS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
CLASSROOM LEARNING	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
LEISURE ACTIVITIES	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

- Do the difficulties put a burden on you or the family as a whole?

Not at all	Only a little	Quite a lot	A great deal
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Signature

Date

Mother/Father/Other (please specify:)

Thank you very much for your help

© Robert Goodman, 2005

Strengths and Difficulties Questionnaire

P 4-17
FOLLOW-UP

For each item, please mark the box for Not True, Somewhat True or Certainly True. It would help us if you answered all items as best you can even if you are not absolutely certain or the item seems daft! Please give your answers on the basis of your child's behaviour over the last month.

Child's Name

Male/Female

Date of Birth.....

	Not True	Somewhat True	Certainly True
Considerate of other people's feelings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Restless, overactive, cannot stay still for long	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Often complains of headaches, stomach-aches or sickness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Shares readily with other children (treats, toys, pencils etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Often has temper tantrums or hot tempers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rather solitary, tends to play alone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Generally obedient, usually does what adults request	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Many worries, often seems worried	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Helpful if someone is hurt, upset or feeling ill	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Constantly fidgeting or squirming	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Has at least one good friend	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Often fights with other children or bullies them	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Often unhappy, down-hearted or tearful	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Generally liked by other children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Easily distracted, concentration wanders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nervous or clingy in new situations, easily loses confidence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kind to younger children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Often lies or cheats	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Picked on or bullied by other children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Often volunteers to help others (parents, teachers, other children)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thinks things out before acting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Steals from home, school or elsewhere	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gets on better with adults than with other children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Many fears, easily scared	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sees tasks through to the end, good attention span	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Do you have any other comments or concerns?

Please turn over - there are a few more questions on the other side

Since coming to the clinic, are your child's problems:

Much worse	A bit worse	About the same	A bit better	Much better
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Has coming to the clinic been helpful in other ways, e.g. providing information or making the problems more bearable?

Not at all	Only a little	Quite a lot	A great deal
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Over the last month, has your child had difficulties in one or more of the following areas: emotions, concentration, behaviour or being able to get on with other people?

No	Yes-minor difficulties	Yes-definite difficulties	Yes-severe difficulties
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If you have answered "Yes", please answer the following questions about these difficulties:

- Do the difficulties upset or distress your child?

Not at all	Only a little	Quite a lot	A great deal
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

- Do the difficulties interfere with your child's everyday life in the following areas?

	Not at all	Only a little	Quite a lot	A great deal
HOME LIFE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
FRIENDSHIPS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
CLASSROOM LEARNING	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
LEISURE ACTIVITIES	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

- Do the difficulties put a burden on you or the family as a whole?

Not at all	Only a little	Quite a lot	A great deal
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Signature

Date

Mother/Father/Other (please specify:)

Thank you very much for your help

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Strengths and Difficulties Questionnaire

Teacher SDQ (SDQ- T)

For each item, please mark the box for Not True, Somewhat True or Certainly True. It would help us if you answered all items as best you can even if you are not absolutely certain or the item seems daft! Please give your answers on the basis of the child's behaviour over the last six months or this school year.

Random participant number (for researcher only):

Considerate of other people's feelings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Restless, overactive, cannot stay still for long	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Often complains of headaches, stomach-aches or sickness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Shares readily with other children (treats, toys, pencils etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Often has temper tantrums or hot tempers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rather solitary, tends to play alone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Generally obedient, usually does what adults request	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Many worries, often seems worried	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Helpful if someone is hurt, upset or feeling ill	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Constantly fidgeting or squirming	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Has at least one good friend	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Often fights with other children or bullies them	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Often unhappy, down-hearted or tearful	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Generally liked by other children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Easily distracted, concentration wanders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nervous or clingy in new situations, easily loses confidence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kind to younger children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Often lies or cheats	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Picked on or bullied by other children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Often volunteers to help others (parents, teachers, other children)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thinks things out before acting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Steals from home, school or elsewhere	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gets on better with adults than with other children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Many fears, easily scared	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sees tasks through to the end, good attention span	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Do you have any other comments or concerns?

Overall, do you think that this child has difficulties in one or more of the following areas:
emotions, concentration, behaviour or being able to get on with other people?

No	Yes-minor difficulties	Yes-definite difficulties	Yes-severe difficulties
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If you have answered "Yes", please answer the following questions about these difficulties:

! How long have these difficulties been present?

Less than a month	1-5 months	6-12 months	Over a year
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

! Do the difficulties upset or distress the child?

Not at all	Only a little	Quite a lot	A great deal
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

! Do the difficulties interfere with the child's everyday life in the following areas?

	Not at all	Only a little	Quite a lot	A great deal
PEER RELATIONSHIPS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
CLASSROOM LEARNING	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

! Do the difficulties put a burden on you or the class as a whole?

Not at all	Only a little	Quite a lot	A great deal
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Signature

Date

Class Teacher/Form Tutor/Head of Year/Other (please specify:)

Strengths and Difficulties Questionnaire (Teacher)

For each item, please mark the box for Not True, Somewhat True or Certainly True. It would help us if you answered all items as best you can even if you are not absolutely certain or the item seems daft! Please give your answers on the basis of the child's behaviour over the last month.

Random participant number (for researcher only):

	Not True	Somewhat True	Certainly True
Considerate of other people's feelings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Restless, overactive, cannot stay still for long	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Often complains of headaches, stomach-aches or sickness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Shares readily with other children (treats, toys, pencils etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Often has temper tantrums or hot tempers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rather solitary, tends to play alone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Generally obedient, usually does what adults request	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Many worries, often seems worried	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Helpful if someone is hurt, upset or feeling ill	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Constantly fidgeting or squirming	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Has at least one good friend	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Often fights with other children or bullies them	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Often unhappy, down-hearted or tearful	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Generally liked by other children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Easily distracted, concentration wanders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nervous or clingy in new situations, easily loses confidence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kind to younger children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Often lies or cheats	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Picked on or bullied by other children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Often volunteers to help others (parents, teachers, other children)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thinks things out before acting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Steals from home, school or elsewhere	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gets on better with adults than with other children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Many fears, easily scared	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sees tasks through to the end, good attention span	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Do you have any other comments or concerns?

Since completing the course, are the child's problems:

Much worse	A bit worse	About the same	A bit better	Much better
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Has completing the course been helpful in other ways, e.g. providing information or making the problems more bearable?

Not at all	Only a little	Quite a lot	A great deal
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Over the last month, has the child had difficulties in one or more of the following areas: emotions, concentration, behaviour or being able to get on with other people?

No	Yes-minor difficulties	Yes-definite difficulties	Yes-severe difficulties
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If you have answered "Yes", please answer the following questions about these difficulties:

! Do the difficulties upset or distress the child?

Not at all	Only a little	Quite a lot	A great deal
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

! Do the difficulties interfere with the child's everyday life in the following areas?

	Not at all	Only a little	Quite a lot	A great deal
PEER RELATIONSHIPS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
CLASSROOM LEARNING	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

! Do the difficulties put a burden on you or the class as a whole?

Not at all	Only a little	Quite a lot	A great deal
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Signature

Date

Class Teacher/Form Tutor/Head of Year/Other (please specify):

Appendix 3: Additional questions for teachers

1. Please comment on the number of absences the child has had from school (in the last month).

2. Please comment on any behavioural incidents the child has been involved (in the last month).

3. Please comment on the child's academic achievement (in the last month)

Appendix 4: Non-standardised questionnaires for Intervention A

Tool B

Mid-way review

- 1) How many sessions have been completed?

- 2) Is your child coping with group session?

- 3) Have you begun to notice any improvements to behaviour?

- 4) How well are they engaging in group sessions?

- 5) Are there additional requirements that may help the participant?

Tool C

Final review

- 1) Do you think the group has helped your child in the last 3 months?

- 2) Do you think the group has helped you in the last 3 months?

- 3) Do you think your child's behaviour has changed as a result of the group?

- 4) Do you think your relationship with your child has changed as a result of the group?

- 5) Do you require further support?

Tool D

Post- intervention group questionnaire

- 1) Can you draw a face or write about how you felt when you first came to the group?
- 2) Can you draw a face or write about how you feel now the group is coming to an end?
- 3) Has the group helped you understand what has happened in your past?
- 4) Has the group helped you to talk to your mum about what has happened?
- 5) What was the best thing that happened in the group?
- 6) What was the worst thing that happened in the group?
- 7) Has the group helped you understand who was responsible for the violence?

8) Did it help talking to other children in the group about the violence in your family?

9) Has the group helped you with your feelings and the way you behave?

10) Do you know who to go to for help or to talk to if you have worries in the future

11) Is there anything else that you would like to tell us?

Appendix 5: Tools E, F, G, H, I

Tool E

Control

These questions relate to how in control you feel of your life and your actions. Please answer them as honestly as you can.

Circle **YES!** if you strongly agree with the statement, **yes** if you somewhat agree, **no** if you somewhat disagree, and **NO!** if you strongly disagree.

- | | |
|---|----------------------------------|
| 1) Other people decide what happens to me. | YES! yes no NO! |
| 2) It is important to think before you act. | YES! yes no NO! |
| 3) If I study hard, I will get better grades. | YES! yes no NO! |
| 4) When I try to be nice, people notice. | YES! yes no NO! |
| 5) If you work hard, you will get what you want. | YES! yes no NO! |
| 6) To make a good decision, it is important to think. | YES! yes no NO! |

² P2.C-IPFI

7) I am responsible for what happens to me. YES! **yes** **no** **NO!**

Sometimes you have to physically fight to
get what you want. YES! **yes** **no** **NO!**

9) I get mad easy. YES! **yes** **no** **NO!**

10) I do whatever I feel like doing. YES! **yes** **no** **NO!**

11) When I am mad, I yell at people. YES! **yes** **no** **NO!**

Sometimes I break things on purpose. YES! **yes** **no** **NO!**

If I feel like it, I hit people. YES! **yes** **no** **NO!**

Tool F

How I feel about myself

These questions ask how you see yourself as a friend, as a son or daughter, and as a student. Please answer as honestly as you can. Circle the number that best fits what you think.

	Strongly disagree	Disagree	Agree	Strongly Agree
1. I am <i>not</i> as popular as other people my age.	1	2	3	4
2. Other people think I am a lot of fun to be with.	1	2	3	4
3. I wish I were a different kind of person because I'd have more friends.	1	2	3	4
4. My parents are proud of the kind of person I am.	1	2	3	4
	Strongly disagree	Disagree	Agree	Strongly Agree
5. No one pays much attention to me at home.	1	2	3	4

² Q2.HA-SSES

6. I often feel unwanted at home.	1	2	3	4
7. My parents believe that I will be a success in the future.	1	2	3	4
8. In the kinds of things we do in school, I am at least as good as other people in my classes.	1	2	3	4
9. I often feel worthless in school.	1	2	3	4
10. I am an important person in my classes.	1	2	3	4

Tool G

How angry do you feel?

How often do you.....

	Never	Once in a while	Fairly often	Most of the time
1. Feel easily annoyed or irritated?	1	2	3	4
2. Have temper outbursts you cannot control?	1	2	3	4
3. Have urges to beat, injure, or harm someone?	1	2	3	4
4. Have urges to break or smash things?	1	2	3	4
5. Get into frequent arguments?	1	2	3	4
6. Shout or throw things?	1	2	3	4

² J1.H-SCL-90

Tool H

Dealing with anger

The following questions look at how you cope with situations that make you angry.

The next time you find yourself really angry at someone or something, how likely is it that you would.....

	Very likely	Likely	Unlikely	Very Unlikely
Ignore the situation?	A	B	C	D
Ignore the situation and get the person later?	A	B	C	D
Try to talk it out?	A	B	C	D
Suggest talking it out?	A	B	C	D
Channel your anger into something constructive?	A	B	C	D
Laugh it off?	A	B	C	D
Try to reduce your anger?	A	B	C	D
Try to see the other person's point of view?	A	B	C	D

Tool I

Managing Anger

How confident do you feel that you could.....	Very confident	Somewhat confident	Unsure	Not very confident	Not at all confident
Stay out of fights?	A	B	C	D	E
Understand another person's point of view?	A	B	C	D	E
Calm down when you are mad?	A	B	C	D	E
Talk out a disagreement?	A	B	C	D	E
Learn to stay out of fights?	A	B	C	D	E

Appendix 6: Tools J and K

Tool J

Outlook on the Future

These questions ask how you feel about your future. Please answer them as honestly as you can.

Circle **YES!** if you strongly agree with the statement, **yes** if you somewhat agree, **no** if you somewhat disagree, and **NO!** if you strongly disagree.

I will probably die before I am thirty.	YES!	yes	no	NO!
I think I will have a nice family when I get older.	YES!	yes	no	NO!
I am afraid my life will be unhappy.	YES!	yes	no	NO!
Bad things happen to people like me.	YES!	yes	no	NO!
I think I can have a nice house when I grow up.	YES!	yes	no	NO!
I will probably never have enough money.	YES!	yes	no	NO!

Tool K

Dating

Age ____

Sex ____

Instructions:

Under each question you will see five response categories, circle the response that best fits you. Use the key below as a guide. Be sure to answer the question appropriate for the gender that you date¹.

Strongly Disagree	Disagree	Neither Agree or Disagree	Agree	Strongly Agree
-2	-1	0	+1	+2

FEMALE: When I see an attractive boy with his girlfriend, I might try to get his attention.

MALE: When I see an attractive girl with her boyfriend, I might try to get her attention.

-2 -1 0 +1 +2

FEMALE: I would rather date several boys at once than just one boy.

MALE: I would rather date several girls at once than just one girl.

-2 -1 0 +1 +2

FEMALE: I think boys find me naturally attractive.

MALE: I think girls find me naturally attractive.

-2 -1 0 +1 +2

4. FEMALE: I like boys more for their good looks than for their companionship.

MALE: I like girls more for their good looks than for their companionship.

-2 -1 0 +1 +2

Strongly Disagree	Disagree	Neither Agree or Disagree	Agree	Strongly Agree
		0		

¹ This version is formatted for heterosexual respondents. A modified version is available for respondents who have same gender relationships.

-2	-1		+1	+2
----	----	--	----	----

FEMALE:I would get back at someone who looked at my boyfriend in the wrong way.

MALE: I would get back at someone who looked at my girlfriend in the wrong way.

-2 -1 0 +1 +2

FEMALE:I would start a relationship with another boy before ending one with my current boyfriend.

MALE: I would start a relationship with another girl before ending one with my current girlfriend.

-2 -1 0 +1 +2

My friends respect me because they know I'm a little wild and crazy.

-2 -1 0 +1 +2

FEMALE:If other girls think I am attractive to boys, they will stay away from my boyfriend.

MALE: If other boys think I am attractive to girls, they will stay away from my girlfriend.

-2 -1 0 +1 +2

FEMALE: Other girls respect me because they know I have a lot of friends who would support me.

MALE: Other boys respect me because they know I have a lot of friends who would support me.

-2 -1 0 +1 +2

FEMALE:If other girls think I am "tough," they will stay away from my boyfriend.

MALE: If other boys think I am "tough," they will stay away from my girlfriend.

-2 -1 0 +1 +2

Appendix 7: Interview guides

Interview guide for interviews with parents

Introduction

- What programme did your child take part in?
- Current family circumstance

Before commencement

- Can you describe how you found out about the programme and what process was involved before your child began the programme?

Parents' expectations of the intervention

- What were your initial expectations of the intervention?
- How do you think your child has felt about coming to the programme?

Impact of programme

- How do you think the intervention has impacted your relationship with your child/your child at home/in school?
- How did the parent sessions help you?
- In what ways could the sessions have been improved?
- What did you like about the parent sessions

Barriers to engagement

- Were there any potential barriers to your child attending/engaging with the programme?
- Were there any potential barriers to you attending/engaging with the programme

Interview guide for follow-up interviews with parents

Introduction

- How long ago did child finish it/How many sessions did they complete? Did they complete it in a group or one to one?

Commencement

- Experience of parent sessions
- Did your child enjoy the programme? Did they have tasks to do outside of the session? What was your experience of these? Were you involved in any of these tasks? Did you talk about what they had learned?
- Did you observe any changes in your child's behaviour while they were involved in the programme? How did it impact their relationship with you?

Barriers to engagement

- What aspects of the children's sessions worked well? Do you think that there are any areas that DVA organisation could improve for future groups?
- Were there any logistical issues that made engagement in the programme difficult? (eg. time and location of child/parent sessions, travel expenses)
- Was there anything about the programme activities, the group of facilitators or anything else that made it difficult for your child to engage?

Post- programme

- How did your child feel about finishing the programme?
- Since finishing the programme have they used any of the techniques they had learned during the programme?
- In what ways do you think the programme has benefited your child/ your relationship with them? Are there other ways in which you feel you have benefited? Please give examples?
- Is there anything you feel that the programme should include that it didn't?

Interview guide for interviews with children

Introduction

- Could you tell me a bit about you? (Age, hobbies, school life)
- Who is in your family?

Purpose

- In your own words, why did you go to the intervention?

Experience

- 3 words to describe intervention
- What did you most enjoy about intervention and why?
- What activities were most memorable and why?
- How easy was it to talk/open up at the intervention? Why?
- What did you think of the facilitators?
- Would you have liked intervention to carry on? Why?

Impact

- What did you learn from the programme?
- Use 3 words to describe your relationship with mum/siblings – after intervention
- Who would you speak to about your feelings? How has intervention helped you?
- Did you use the talking to my mum book? How did it help/not help?
- How would you describe your experience of the programme to other people?
- What were the 3 most important things you learned from the programme?
- Why/why not would you recommend the programme to another child?
- What do you want for yourself and your family in the future?

Interview guide for interviews with intervention facilitators

Introduction:

- Describe your role as facilitator.
- Which interventions are you involved with?
- How long have you been in this role? What training did you receive for this role?

Programme design:

- In your own words, can you describe the children and young people's programmes with regard to their purpose and how they are delivered?
- What are the overall goals of the programme?

Reach and demand:

- How do each of the programmes compare to other existing resilience building/trauma recovery programmes in your locality (both in terms of purpose and delivery)?
- How are children referred to each of the programmes?
- To what extent are parents' involvements in the programme significant for the outcomes?

Treatment process, drop out and retention:

- Talk me through how you prepare for the programme sessions.
- Are there any particular motivational factors which make children and young people more likely to progress successfully through the programmes?
- For what reasons might children be removed from the programme? For what reasons might they be reinstated? Is any work done with children to help them be reinstated?
- To what extent are the programme activities flexible? Are sessions too restrictive? Do you get any feedback about the sessions from facilitators in terms of case updates and how sessions are run?
- Which activities do you think seem to have the most impact (positive and negative) on children?
- To what extent do parents/schools get involved in the programmes? How critical is it that either parents or schools get involved?
- Are there any factors that have facilitated the successful running of sessions? What factors hindered the successful running of sessions? What could be done to improve the successful running of sessions? (e.g. extra money to pay for travel)
- Do the children/parents often come up against barriers? If so, what type of barriers did they face?
- To what extent is the personality of the staff and the children important for success? (were they sentimental/ grounded / supportive etc).

- To what extent do you think that logistical issues affect the smooth running of sessions, e.g. location, venue, access, ability to travel and pay for travel

Outcomes:

- What does success look like for children and young people once they complete the programmes – how might this be measured?
- What proportion of those who complete the interventions benefit from it? And can you describe the ways in which they benefited? Do you have any follow up contact with the children and families? Have there been any cases where children are re-referred?

Coordination of the programme

- How many other facilitators do you lead with? What happens when there is a shortage of facilitators?
- Can you explain how your role as facilitator is reviewed, and how you receive feedback?
- How often do you, the programme coordinator, and the programme developer/consultant meet together for supervision?

Final thoughts

- In what ways do you think the coordination, delivery and design of the programmes could be improved?
- If you could change one thing what would it be? What is your main struggle?
- What factors are essential for the success of the programmes?

Interview guide for interview with coordinator/CEO/manager

Introduction:

- In your own words, describe your role at DVA organisation with regard to the children and young people's programmes?
- How long have you been in this role? What training did you receive for this role?

Programme design:

- In your own words, can you describe the children and young people's programmes with regard to their purpose and how they are delivered? How long have these programmes been running for?
- What are the overall goals of the programme?

Reach and demand:

- How do each of the programmes compare to other existing resilience building/trauma recovery programmes in your locality (both in terms of purpose and delivery)?
- How are children referred to each of the programmes?
- Under what circumstances would you close a referral case? In cases where a child moves locality and a case is closed, do you provide them with any information for support they could receive in a different area?
- How do you think the referral process could be improved? How long is the average wait between referral and commencement? Has this time period changed over time?

Treatment process, drop out and retention:

- Is any work done with children and parents to prepare them for the programme?
- Are there any particular motivational factors which make children and young people more likely to progress successfully through the programmes?
- For what reasons might children be removed from the programme?
- Do you think that the programmes are flexible in relation to the suggested activities? Do you get any feedback about the sessions from facilitators in terms of case updates and how sessions are run?
- Which activities do you think seem to have the most impact on children?
- Are there any factors that have facilitated the successful running of sessions? What factors hindered the successful running of sessions? What could be done to improve the successful running of sessions? (e.g. extra money to pay for travel)
- To what extent is the personality of the staff and the children important for success? (were they sentimental/ grounded / supportive etc).
- To what extent do you think that logistical issues affect the smooth running of sessions, e.g. location, venue, access, ability to travel and pay for travel
- Do the children/parents often come up against barriers? If so, what type of barriers did they face?

Outcomes:

- What does success look like for children and young people once they complete the programmes – how might this be measured?
- What do you think the children and parents think the outcomes of the programmes are?
- What proportion of those who complete the interventions benefit from it? And can you describe the ways in which they benefited?
- To what extent do parents/schools get involved in the programmes? How critical is it that either parents or schools get involved? Do you think that involvement has any impact on outcomes?

Coordination of the programmes

- How many facilitators are there currently per programme? Do any facilitators facilitate on multiple programmes (children/adult)? What are the positive /negative impacts of having facilitators based in other locations? Do you have less contact with them?
- Can you explain how you review facilitators' delivery of the programmes?
- How often do the facilitator teams, you, and the programme developer meet together for supervision?

Final thoughts

- In what ways do you think the coordination, delivery and design of the programmes could be improved?
- If you could change one thing what would it be? What is your main struggle?
- What factors are essential for the success of the programmes?
- What avenues do you view as being viable for securing future funding and why?

Interview guide for interview with author of Interventions B and C

Introduction:

- Describe your role with regard to the children and young people's programmes/your training/expertise

Programme design:

- Talk me through your approach when developing the programmes (prompts about why the programmes were developed the way it was, would any different processes be adopted in hindsight)
- Can you explain the different modules/sessions incorporated into the programmes?
- What research/ personal experience have you drawn upon to help you develop an understanding of the programme design (sequential order) and the programme outcomes?
- When designing the programmes, what did you envisage client success looking like for each of the sessions? How did you think that this would be measured/ evidenced?
- What factors do you think facilitate the effective delivery of the children and young people's' programme and why?

Reach and demand:

- How do each of the programmes compare to other existing resilience building programmes?
- How are children referred to each of the programmes? Does the referral route have any particular impact on the types of people/families referred or on motivation or outcomes?
- To what extent are parents responsive when they are contacted about their child's participation in the programmes?

Treatment process, drop out and retention:

- Is any work done with children and parents to prepare them for the programme?
- Are there any particular motivational factors which make children and young people more likely to progress successfully through the programmes?
- For what reasons might children be removed from the programme? For what reasons might they be reinstated?
- To what extent are the programme activities flexible? Do you get any feedback about the sessions from facilitators in terms of case updates and how sessions are run?
- Which activities do you think seem to have the most impact on children?
- To what extent do parents/schools get involved in the programmes? What impact does either parents or schools have on outcomes?

- Are there any factors that have facilitated the successful running of sessions?
What factors hindered the successful running of sessions? What could be done to improve the successful running of sessions? (e.g. extra money to pay for travel)
- Do the children/parents often come up against barriers? If so, what type of barriers did they face?
- To what extent is the personality of the staff and the children important for success? (were they sentimental/ grounded / supportive etc).
- To what extent do you think that logistical issues affect the smooth running of sessions, e.g. location, venue, access, ability to travel and pay for travel

Outcomes:

- What do you think the children and parents think the outcomes of the programmes are?
- What does success look like for children and young people once they complete the programmes – how might this be measured?

Coordination of the programme

- Can you explain the internal evaluation process of reviewing of facilitators' delivery?
- How often do the facilitator teams meet together for supervision?

Final thoughts

- In what ways do you think the coordination, delivery and design of the programmes could be improved?
- If you could change one thing what would it be? What is your main struggle?
- What factors are essential for the success of the programmes?

Appendix 8: Parent recruitment flier



Research Participation!

Researchers in the Department of Psychological Sciences at the University of Liverpool are seeking parents to take part in a one-to-one interview with a researcher. We would like to hear **your** feedback on the service provided by XXXX. Interviews will last between **30 minutes to one hour** and will be **strictly confidential**. We are seeking to talk to parents who:

- Have a child attending one of the following programmes: XXXX, XXXX, XXXX
- Are fluent English speakers



Please note that all interviews are intended to take place at XXXX

For further information or if you would like to take part, please email Grace McGuire at g.mcguire@liv.ac.uk or ring XXXX

Appendix 9: Glossary of participants in Study 2

Child	Parent	Intervention
Kwaii-Chan	Jackie	Intervention A
Penny	Zoe	Intervention A
Cinderella	Naomi	Intervention A
Not interviewed	Fiona	Intervention B
Not interviewed	Elaine	Intervention B
Not interviewed	Steve	Intervention B

Intervention provider	Role	Intervention	Internal or external to DVA organisation
Helen	Facilitator	Intervention A	External
Vicky	Facilitator	Intervention A	External
Sue	Facilitator	Intervention A	External
Sandra	Facilitator	Intervention A	External
Emma	Facilitator	Intervention A	Internal
Zara	Facilitator	Interventions A and B	External
Mike	Facilitator	Intervention B	Internal
Joe	Facilitator	Intervention B	External
Eleanor	Facilitator and Interventions' Coordinator	All	External
Chrissie	Intervention Author	Interventions B and C	External
Simone	CEO of DVA organisation	All	Internal
Carol	Manager of partner organisation	Intervention A	External

Appendix 10: Study 2-Ethical approval details and proof of confirmation

Details of ethical approval

Ethics REF	Date of approval after amendments	Details
RETH000749	28/8/14 (see Appendix 6)	<ul style="list-style-type: none"> Approval to conduct interviews with parents
	16/1/15	<ul style="list-style-type: none"> Approval to conduct follow-up interview with parents and interviews (including follow-up) with intervention providers
RETH001004	01/03/16	<ul style="list-style-type: none"> Approval to conduct interviews with children

Ethical approval confirmation of intervention provider interviews and follow-up interviews with parents, after amendment to ethics REF: RETH000749



Ethics
Fri 16/01/2015, 17:20



Dear Professor Alison and Miss McGuire,

I am pleased to inform you that the Sub-Committee has approved the amendment to your study. Details and conditions of the approval can be found below.

Ref:	RETH000749
Review type:	Amendment
Principle Investigator:	Professor Laurence Alison
Student Investigator:	Miss Grace McGuire
Department:	Psychological Sciences
Title:	Evidence based solutions to reducing domestic violence- examining outcome measures and impact of whole family service interventions.
First Reviewer:	Dr Mark O'Brien
Date of initial review:	16/12/2014
Date of Approval:	16/01/2015

The amendment was APPROVED subject to the following conditions:

All serious adverse events must be reported to the Sub-Committee within 24 hours of their occurrence, via the Research Integrity and Governance Officer (ethics@liv.ac.uk).

This approval applies for the duration of the research. If it is proposed to extend the duration of the study as specified in the application form, the Sub-Committee should be notified. If it is proposed to make an amendment to the research, you should notify the Sub-Committee by following the Notice of Amendment procedure outlined at <http://www.liv.ac.uk/media/livacuk/researchethics/notice%20of%20amendment.doc>. If the named PI / Supervisor leaves the employment of the University during the course of this approval, the approval will lapse. Therefore please contact the Research Integrity and Governance Officer at ethics@liverpool.ac.uk in order to notify them of a change in PI / Supervisor.

Kind regards,

Matthew

Matthew Billington
Research Integrity and Governance Officer

Research Support Office
University of Liverpool
Waterhouse Building (2nd Floor, Block C)
3 Brownlow Street
Liverpool

Ethical approval confirmation of interviews with children ethics REF: RETH001004

RETH001004: Research ethical approval



Ethics

Tue 01/03/2016, 13:58

Perkins, Elizabeth; McGuire, Grace; Alison, Laurence

🔄 Reply all | ▼

Dear all,

I am pleased to inform you that your application for research ethical approval to your study has been approved. Details and conditions of the approval can be found below.

Ethics reference number: RETH001004

Committee name: Research Ethics Subcommittee for Non-Invasive Procedures

Review type: Full committee review

Title of study: Children's' experiences of participating in trauma recovery and resilience building programmes (Children's experiences of intervention programmes)

Principal Investigator: Professor Liz Perkins

Student Investigator: Miss Grace McGuire

Co-Applicant: Professor Laurence Alison

School/Institute: Health Services Research, Institute of Psychology, Health and Society

First reviewer: Professor Harold Mytum

Approval date: 01/03/16

The application was APPROVED subject to the following conditions:

Conditions

All serious adverse events must be reported to the Subcommittee within 24 hours of their occurrence, via the Research Integrity and Governance Officer (ethics@liverpool.ac.uk).

This approval applies for the duration of the research. If it is proposed to extend the duration of the study as specified in the application form, the Subcommittee should be notified. If it is proposed to make an amendment to the research, you should notify the Committee by following the Notice of Amendment procedure. If the named PI / Supervisor leaves the employment of the University during the course of this approval, the approval will lapse. Therefore please contact the Research Integrity and Governance Officer at ethics@liverpool.ac.uk in order to notify them of a change in PI / Supervisor.

Kind regards,

Mantelena

Mantelena Sotiriadou
Research Ethics and Integrity Officer

Research Support Office
University of Liverpool
Waterhouse Building (2nd Floor, Block C)
3 Brownlow Street
Liverpool
L69 3GL

Appendix 11: Information sheets and consent forms for interviews with parents and intervention providers



Participant information sheet- (for parents)

Research project: Evidence based solutions to reducing domestic violence- examining outcome measures and impact of whole family service interventions

You are being invited to participate in a research study. Before you decide whether to participate, it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and feel free to ask us if you would like more information or if there is anything that you do not understand. Please also feel free to discuss this with your friends, relatives and GP if you wish. We would like to stress that you do not have to accept this invitation and should only agree to take part if you want to.

1. What is the purpose of the study?

As XXXX aims to involve parents in the intervention process for intervention programmes delivered for children and young people, we think that it is important to invite you to provide your feedback on the programme and parents' sessions provided by XXXX.

2. Why have I been invited to take part?

We are inviting parents who have a child that participated on one of the following programmes- XXXX, XXXX, or XXXX, to take part in a 1 hour one to one interview with a researcher. We feel it important to gain your perspective on what impact the intervention programmes have had for you and your child. We are evaluating the services provided by XXXX and would like to give them helpful feedback about how they deliver the programmes and engage with families.

3. Do I have to take part?

No, your participation in providing consent is completely voluntary. You are also free to withdraw at any time should you decide that you no longer wish to take part.

4. What will happen if I take part?

Should you wish to participate in the interview, the researcher will arrange an interview time on a date most convenient for you. The interview will take place on XXXX premises and will last between 30 minutes to 1 hour. You will have a discussion about what your expectations of the intervention were at the beginning of the intervention process, what impact the programme has had on your relationship with your child, whether there were any barriers to you/your child engaging in the programme sessions, and your experience of the whole family service. The interview will be recorded on a Dictaphone, and then it will be transcribed. Following this, the recording will be deleted. Any information that you shared with the researcher will be confidential even if a complaint or negative comment has been made against the service. Your comments will remain anonymous in order to protect your identity and this incorporates your anonymity in the write-up of the findings. Should you share something that you feel would benefit the service provided by XXXX, you will be asked whether you would like the researcher to provide feedback of your comments with XXXX during established stakeholder meetings, but your identity will remain anonymous. A pseudonym will be used rather than your real name. Any information that you do share will not affect the quality

of the service you receive. XXXX are more than happy to receive feedback, especially as this may help them improve their service.

5. Are there any benefits to taking part?

It is hoped that your participation will help the researchers provide constructive feedback for the services provided by XXXX for the future development of their programmes and support for families.

6. Will my participation be kept confidential?

All data attained from the study is for research purposes only. You and your child will not personally identifiable from reports that are written as a result of the data collection.

7. Are there any risks in taking part?

There are no physical risks to you should you take part. However, any safeguarding disclosures made by school staff that requires statutory action will be reported to XXXX for the purpose of safeguarding children.

8. What should I do if I have any questions?

Please feel free to let us know by contacting the Principal Investigator, Professor Laurence Alison via e-mail at l.j.alison@liverpool.ac.uk and we will try to help. If you have a complaint which you feel you cannot come to us with then you should contact the Research Governance Officer at ethics@liv.ac.uk. When contacting the Research Governance Officer, please provide details of the name or description of the study (so that it can be identified), the researcher(s) involved, and the details of the complaint you wish to make.

If you have any further queries about taking part in this research or questions about the aims of the research in general, please do not hesitate to contact the Principal Investigator.

Thank you for taking the time to read this information sheet. If you would like to take part in this research then please read and sign the attached consent form.

Committee on Research Ethics

PARTICIPANT CONSENT FORM (for parents)

Title of Research Project: Evidence based solutions to reducing domestic violence-
examining outcome measures and impact of whole family service interventions

Researcher(s): Professor Laurence Alison and Grace McGuire

**Please
initial
box**

1. I confirm that I have read and have understood the information sheet dated 14th Aug 2014 for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. ☐
2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my rights being affected. ☐
3. I understand that, under the Data Protection Act, I can at any time ask for access to the information I provide and I can also request the destruction of that information if I wish. ☐
4. I understand that confidentiality and anonymity will be maintained and it will not be possible to identify me in any publications. ☐
5. I understand that the interview will be audio recorded using a Dictaphone, but it will be transcribed for data collection purposes and then later deleted. ☐
6. I understand that any negative comments or complaints I make against the service during the intr will be confidential. I understand that should I wish the researcher to share these in stakeholder meetings with XXXX if I feel comments may help improve the service I will provide permission for the researcher to do so. I understand that my identity will be protected. I understand this will not affect the quality of the service I receive and that XXXX are happy to receive feedback. ☐
7. I agree to take part in the above study ☐

_____	_____	_____
Participant Name	Date	Signature
_____	_____	_____
Name of Person taking consent	Date	Signature
_____	_____	_____
Researcher	Date	Signature

Principal Investigator:

Name- Professor Laurence Alison
 Work Address- Eleanor Rathbone Building,
 Bedford Street South, Liverpool, L69 6ZA
 Work Email- l.j.alison@liverpool.ac.uk

Student Researcher:

Name- Grace McGuire
 Work Address- Eleanor Rathbone Building
 Bedford Street South, Liverpool, L69 6ZA
 Work Email- g.mcguire@liv.ac.uk



Participant information sheet- (for parents, follow-up)

Research project: Evidence based solutions to reducing domestic violence- examining outcome measures and impact of whole family service interventions

You are being invited to participate in a research study. Before you decide whether to participate, it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and feel free to ask us if you would like more information or if there is anything that you do not understand. Please also feel free to discuss this with your friends, relatives and GP if you wish. We would like to stress that you do not have to accept this invitation and should only agree to take part if you want to.

1. What is the purpose of the study?

The aim of this study is to gain your feedback with regard to the intervention programme delivered by XXXX that you and your child participated on. As the intervention programme has now ended, it is important that we capture your views on the delivery and impact of the intervention programme in addition to further exploring issues that were raised in the first interview.

2. Why have I been invited to take part?

We are inviting parents who previously participated in an interview when their child participated on XXXX, XXXX, or XXXX intervention programme, to take part in a follow-up one to one interview with the same researcher. We feel it important to gain your perspective and experience of the intervention programme.

3. Do I have to take part?

No, your participation in providing consent is completely voluntary. You are also free to withdraw at any time should you decide that you no longer wish to take part.

4. What will happen if I take part?

Should you wish to participate in the interview the researcher will arrange the interview for a time that is most convenient and comfortable for you. The interview will last for approximately 1 hour. You will be asked to share your thoughts and experiences of the intervention programme from your perspective and may also be asked to clarify any comments that you made in the previous interview. You are free to withdraw at any time during the interview if you no longer wish to take part and are not required to answer all questions asked by the interviewer if you do not feel comfortable. The interview will be recorded on a Dictaphone, and then it will be transcribed. Following this, the recording will be deleted. Any information that you shared with the researcher will be confidential even if a complaint or negative comment has been made against the service. Your comments will remain anonymous in order to protect your identity and this incorporates your anonymity in the write-up of the findings. A pseudonym will be used rather than your real name.

5. Are there any benefits to taking part?

It is hoped that your participation will help the researchers provide constructive feedback for XXXX for the future development of their programmes and support for families.

6. Will my participation be kept confidential?

All data attained from the study is for research purposes only. You and your child will not personally identifiable from reports that are written as a result of the data collection.

7. Are there any risks in taking part?

There are no physical risks to you should you take part. However, any safeguarding disclosures that are made will be reported to XXXX for the purpose of safeguarding children.

8. What should I do if I have any questions?

Please feel free to let us know by contacting the Principal Investigator, Professor Laurence Alison via e-mail at l.j.alison@liverpool.ac.uk and we will try to help. If you have a complaint which you feel you cannot come to us with then you should contact the Research Governance Officer at ethics@liv.ac.uk. When contacting the Research Governance Officer, please provide details of the name or description of the study (so that it can be identified), the researcher(s) involved, and the details of the complaint you wish to make.

If you have any further queries about taking part in this research or questions about the aims of the research in general, please do not hesitate to contact the Principal Investigator.

Thank you for taking the time to read this information sheet. If you would like to take part in this research then please read and sign the attached consent form.



Committee on Research Ethics

PARTICIPANT CONSENT FORM (for parents)

Please
initial
box

Title of Research Project: Evidence based solutions to reducing domestic violence-
examining outcome measures and impact of whole family service interventions

Researcher(s): Professor Laurence Alison and Grace McGuire

1. I confirm that I have read and have understood the information sheet dated 24th Sept 2015 for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.
2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my rights being affected.
3. I understand that, under the Data Protection Act, I can at any time ask for access to the information I provide and I can also request the destruction of that information if I wish.
4. I understand that confidentiality and anonymity will be maintained and it will not be possible to identify me in any publications.
5. I understand that the follow-up interview will be audio recorded using a Dictaphone, but it will be transcribed for data collection purposes and then later deleted
6. I agree to take part in the above study

☐☐☐☐☐☐

Participant Name

Date

Signature

Name of Person taking consent

Date

Signature

Researcher

Date

Signature

Principal Investigator:

Name- Professor Laurence Alison
Work Address- Eleanor Rathbone Building,
Bedford Street South, Liverpool, L69 6ZA
Work Email- l.j.alison@liverpool.ac.uk
Version 1: 24th Sept 2015

Student Researcher:

Name- Grace McGuire
Work Address- Eleanor Rathbone Building
Bedford Street South, Liverpool, L69 6ZA
Work Email- g.mcguire@liv.ac.uk

Participant information sheet- (for providers)

Research project: Evidence based solutions to reducing domestic violence- examining outcome measures and impact of whole family service interventions

You are being invited to participate in a research study. Before you decide whether to participate, it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and feel free to ask us if you would like more information or if there is anything that you do not understand. Please also feel free to discuss this with your friends, relatives and GP if you wish. We would like to stress that you do not have to accept this invitation and should only agree to take part if you want to.

1. What is the purpose of the study?

The aim of this study is to capture your thoughts and reflections with regard to the intervention programmes delivered by XXXX for children and young people. It is important that we continue to capture your views on the delivery and evaluation of the intervention programmes and clarify comments that were made in the earlier interview.

2. Why have I been invited to take part?

We are inviting intervention programme stakeholders to take part in an interview and follow-up interview regarding the intervention programmes for children and young people delivered by XXXX, to participate in a one to one follow- up interview with the same researcher.

3. Do I have to take part?

No, your participation in providing consent is completely voluntary. You are also free to withdraw at any time should you decide that you no longer wish to take part.

4. What will happen if I take part?

Should you wish to participate in the interview the researcher will arrange the interview for a time that is most convenient and comfortable for you. The interview will last for approximately 1 hour. You will be asked to share your thoughts and experiences of the intervention programme, provide feedback on the impact of the programme since its completion and may also be asked to clarify any comments that you made in the previous interview. You are free to withdraw at any time during the interview if you no longer wish to take part and are not required to answer all questions asked by the interviewer if you do not feel comfortable. The interview will be recorded on a Dictaphone, and then it will be transcribed. Following this, the recording will be deleted. Any information that you shared with the researcher will be confidential even if a complaint or negative comment has been made against the service. Your comments will remain anonymous in order to protect your identity and this incorporates your anonymity in the write-up of the findings. A pseudonym will be used rather than your real name.

5. Are there any benefits to taking part?

It is hoped that your participation will help the researchers provide constructive feedback for the services provided by XXXX for the future development of their programmes and support for families.

6. Will my participation be kept confidential?

All data attained from the study is for research purposes only. You will not personally identifiable from reports that are written as a result of the data collection.

7. Are there any risks in taking part?

There are no physical risks to you should you take part. However, any safeguarding disclosures made by school staff that requires statutory action will be reported to XXXX for the purpose of safeguarding children.

8. What should I do if I have any questions?

Please feel free to let us know by contacting the Principal Investigator, Professor Laurence Alison via e-mail at l.j.alison@liverpool.ac.uk and we will try to help. If you have a complaint which you feel you cannot come to us with then you should contact the Research Governance Officer at ethics@liv.ac.uk. When contacting the Research Governance Officer, please provide details of the name or description of the study (so that it can be identified), the researcher(s) involved, and the details of the complaint you wish to make.

If you have any further queries about taking part in this research or questions about the aims of the research in general, please do not hesitate to contact the Principal Investigator.

Thank you for taking the time to read this information sheet. If you would like to take part in this research then please read and sign the attached consent form.

Committee on Research Ethics

PARTICIPANT CONSENT FORM (for providers)

Title of Research Project: Evidence based solutions to reducing domestic violence examining outcome measures and impact of whole family service interventions

Please
initial
box

Researcher(s): Professor Laurence Alison and Grace McGuire

1. I confirm that I have read and have understood the information sheet dated 14th Aug 2014 for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. ☐
2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my rights being affected. ☐
3. I understand that, under the Data Protection Act, I can at any time ask for access to the information I provide and I can also request the destruction of that information if I wish. ☐
4. I understand that confidentiality and anonymity will be maintained and it will not be possible to identify me in any publications. ☐
5. I understand that the follow-up interview will be audio recorded using a Dictaphone, but it will be transcribed for data collection purposes and then later deleted. ☐
6. I agree to take part in the above study ☐

_____ Participant Name	_____ Date	_____ Signature
_____ Name of Person taking consent	_____ Date	_____ Signature
_____ Researcher	_____ Date	_____ Signature

Principal Investigator:

Name- Professor Laurence Alison
Work Address- Eleanor Rathbone Building,
Bedford Street South, Liverpool, L69 6ZA
Work Email- l.j.alison@liverpool.ac.uk

Student Researcher:

Name- Grace McGuire
Work Address- Eleanor Rathbone Building
Bedford Street South, Liverpool, L69 6ZA
g.mcguire@liv.ac.uk

Version 1: 24th Sept 2015

Appendix 12: Information sheets and consent forms for interviews with children



Committee on Research Ethics

Participant Information Sheet (for parents)

Children's' experiences of participating in trauma recovery and resilience building programmes

- My name is Grace McGuire and I am inviting your son/daughter to take part in a study about the experiences of children who attended the XXXX programme.
- From this study we hope that we can understand your child's opinions as this is important for supporting children in the future
- To help you decide whether you would be happy for your child to take part, this sheet will answer some questions you may have. You and your child do not have to accept this invitation and should only agree to take part if you are both happy.
- Please take time to read this information carefully and discuss it with your child. Please also feel free to discuss this with your friends, relatives and GP if you wish.
- Please feel free to ask if you would like more information or if there is anything you do not understand.

Q: What is the purpose of the study?

A: We would like to understand from your child's point of view, what it is like to take part in XXXX whether it has changed their life and relationships. We hope this might help other young people who take part in XXXX in the future and help professionals support children who are in a similar situation.

Q: Why has my child been chosen to take part?

A: Your child has been invited to take part in the study because they have attended the XXXX programme.
✓ Other children and young people who have attended these programmes have also been invited to take part.

Q: Does my child have to take part?

A: No. Your child does not have to take part in this study.
✓ If you agree to let your child take part in this study but change your mind later that is fine. A reason does not have to be given.
✓ In all cases your child will receive a £10 gift voucher to thank them for their time.

Q: What will happen if I take part?

A: If you and your child are happy and decide to take part, your child will be invited to talk with me (Grace) about XXXX.

- ✓ You can both pick the time and place for our talk.
- ✓ If your child would feel more comfortable, you are most welcome to stay with them or wait nearby while we talk
- ✓ I will ask your child some questions about the programme, such as what they enjoyed or disliked, and how it might have changed their life and relationships.
- ✓ They do not have to answer all the questions.
- ✓ They can decide what to talk about, I will listen to what they say, and they can ask questions too. If they would

prefer, they can draw their answers using pen and paper which I will provide.

- ✓ There are no right or wrong answers to the questions. This is not a test. I want to listen to their opinions.
- ✓ The talk will last for as long as your child likes, and they can have breaks.
- ✓ I will record our talk using a Dictaphone, so I can type it on the computer. I will then delete the recording. The Dictaphone will only pick up sound, it will not video your child.
- ✓ This study is for my university work, so I would like to write about what your child and other children tell me. I will not use their real name when I write, but they can decide a fake name for me to use. If they don't want to, I can choose one. Nobody will be able to personally identify your child or anyone else mentioned if they take part.

Q: Are there any risks in taking part?

A: There are no physical risks or disadvantages from taking part. If your child feels upset at any point in our talk we will pause the interview before deciding if they would like to continue or not.

Q: Are there any benefits in taking part?

A: Taking part in this study gives your child the chance to share their own opinions about XXXX without anyone else hearing what they say. What they tell me may help children who attend the programme in the future.

Q: What if my child is unhappy or if there is a problem?

A: If you are unhappy, or if there is a problem, please feel free to let us know by contacting Liz Perkins by ringing [0151 7945909] and we will try to help. If you remain unhappy or have a complaint which you feel you cannot come to us with then you should contact the Research Governance Officer at ethics@liv.ac.uk. When contacting the Research Governance Officer, please provide details of the name or description of the study (so that it can be identified), the researcher(s) involved, and the details of the complaint you wish to make.

Q: Will my child's participation be kept confidential?

A: The interview will be kept private and confidential.

- ✓ The only time I may have to tell someone what was said, is if your child says something that makes me concerned about their safety or if they disclose serious criminal activity, I may need to pass the information on to a professional who could help.
- ✓ Only myself and the Principal investigator will have access to our talk which will be typed up and safely stored at the university. Your child's personal details will also be safely and securely stored so no one else can see it. All the information will be stored for up to 5 years.

Q: What will happen to the results of the study?

A: In order to protect your child's identity and safety, no individual will be identifiable from the results. The findings from all the talks I have with your child and other children will be written up and may be published. If published they will be available on the internet in a scholarly journal. The findings will also be made available to the staff at XXXX to help them develop the programmes, taking into account the opinions of the children.

Q: What will happen if I want to stop taking part?

A: Your child can withdraw at any time without telling me why. If they decide to withdraw they can decide whether or not they would like me to delete and destroy the interview before it is anonymised or whether they are happy for me to use some of it.

Q: Who can I contact if I have further questions?

A: Please contact Professor Liz Perkins, University of Liverpool, Eleanor Rathbone Building, 74 Bedford Street South, Liverpool, L69 7ZQ. Telephone Number 44 (0) 151 7945909. Email: e.perkins@liv.ac.uk

Q: Criminal Records Bureau check (CRB)

A: I have obtained a CRB Disclosure and you can request evidence of the Disclosure from the Principal Investigator (Liz Perkins).Version 2 29/1/16

PARTICIPANT CONSENT FORM (parents)

Title of Research Project: Children's' experiences of participating in trauma recovery and resilience building programmes

Researcher(s): Prof Elizabeth Perkins and Grace McGuire

Please
initial
box

1. I confirm that I have read and have understood the information sheet dated [29/1/16] for the above study. I have had the opportunity to think about the information, ask questions and have had these answered. ☐
2. I understand that taking part in the interview is mine and my child's choice and they can stop the interview at any time without giving any reason, without their rights being affected. I understand that they do not have to answer all the interview questions. ☐
3. I understand that, under the Data Protection Act, they can at any time ask for access to the information they provide and I can also ask that the information is destroyed. ☐
4. I understand that it will not be possible to identify my child, me or anyone else in the write up of the study. ☐
5. I understand and agree that my child's participation will be audio recorded. I am aware of and consent to your use of these recordings so that you can type up the talk. ☐
6. I agree for my child to take part in the above study. ☐

Participant Name (parent)	Date	Signature
_____	_____	_____

Name of Person taking consent	Date	Signature
_____	_____	_____

Researcher	Date	Signature
_____	_____	_____

Principal Investigator:

Name: Prof Elizabeth Perkins
Work Address: Eleanor Rathbone Building,
74 Bedford Street South
Liverpool L69 7ZA
Work Telephone: 0151 7945909
Work Email: e.perkins@liv.ac.uk

Student Researcher:

Name: Grace McGuire
Work Address: Eleanor Rathbone Building,
74 Bedford Street South
Liverpool L69 7ZQ
Work Email: g.mcguire@liv.ac.uk
Version 2: 29/1/16

Participant Information Sheet (for children)

Children's' experiences of participating in trauma recovery and resilience building programmes

- My name is Grace McGuire and I am inviting you to take part in a study about your experiences of attending the XXXX programme.
- From this study we hope that we can understand your opinions as this is important for supporting children in the future.
- To help you decide whether you would like to take part, this sheet will answer some questions you may have. You do not have to take part in this research and you should only agree to take part if you want to
- Please take time to read this information carefully and discuss it with a parent. Please also feel free to discuss this with your friends, relatives and GP if you wish.
- Please feel free to ask if you would like more information or if there is anything you do not understand

Q: What is the purpose of the study?

A: We would like to understand what it is like to take part in XXXX, and whether it has changed your life and relationships. We hope this might help improve these services.

Q: Why have I been chosen to take part?

A: You have been invited to take part in the study because you have attended the XXXX programme.

- ✓ Children and young people who have also attended these programmes have been invited to take part.

Q: Do I have to take part?

A: No. You do not have to take part in this study – it is completely up to you.

- ✓ If you decide that you want to take part but change your mind later that is fine.
- ✓ You can decide to stop taking part at any time, without explaining why.
- ✓ In all cases you will receive a £10 gift voucher to thank you for your time.

Q: What will happen if I take part?

A: If you decide to take part, you will be invited to talk with me (Grace) about XXXX.

- ✓ You can pick the time and place for our talk.
- ✓ If you want you parent can stay with you or wait close by while we talk
- ✓ I will ask you some questions about the programme, what things you enjoyed or disliked, and how it might have changed your life and relationships.
- ✓ You do not have to answer all the questions.
- ✓ You can decide what to talk about and I will listen to what you say, and you can ask questions too.
- ✓ If you would like to, you can draw your answers using pen and paper.
- ✓ There are no right or wrong answers to the questions. This is not a test. I want to listen to your opinions.
- ✓ The talk will last for as long as you like, and you can have breaks.
- ✓ I will record our talk using a Dictaphone, so I can type it up on the computer. I will then delete the recording. The Dictaphone will only pick up our voices, it will not video you.
- ✓ This study is for my university work, so I would like to write about what you and other children tell me. I will not

use your real name when I write, but you can decide a fake name for me to use. If you don't want to, I can choose one.

Q: Are there any risks in taking part?

A: There are no physical risks or disadvantages from taking part.

- ✓ If you feel upset at any point in our talk please let me know straight away and we will pause the interview.
- ✓ If you do tell me something that makes me very concerned about your safety I may have to tell a professional who can help. But I will not do this without telling you first.

Q: Are there any benefits in taking part?

A: Taking part in this study gives you the chance to share your own opinions about XXXX without anyone else hearing what you say. What you tell me may help children who attend the programmes in the future.

Q: What if I am unhappy or if there is a problem?

A: If you are unhappy, or if there is a problem, please feel free to let us know by contacting Liz Perkins [by ringing 151 7945909] and we will try to help. If you remain unhappy or have a complaint which you feel you cannot come to us with then you should contact the Research Governance Officer at ethics@liv.ac.uk. When contacting the Research Governance Officer, please provide details of the name or description of the study (so that it can be identified), the researcher(s) involved, and the details of the complaint you wish to make.

Q: Are there any times you would tell someone else what I said?

A: Our recorded talks will be kept private and confidential.

- ✓ The only time I may have to tell someone what you have said, is if you say something that makes me concerned about your safety or if you disclose serious criminal activity, I may need to pass the information on to a professional who is able to help. But I will not do this without telling you first.
- ✓ Only the research team will have access to our talk which will be typed up and safely stored at the university. Your personal details will also be safely and securely stored so no one else can see it. All the information will be stored for up to 5 years.

Q: What will happen to the results of the study?

A: The findings from all the talks I have with you and other children will be written up and may be published. If published they will be available on the internet. The findings will also be made available to the staff at XXXX to help them think about how to improve their services. Nobody will be able to know that you personally have taken part.

Q: What will happen if I want to stop taking part?

A: You can stop taking part at any time without telling me why. If you decide to stop taking part you can decide whether or not you would like me to delete and destroy the voice recording of our talk before it is anonymised or whether you are happy for me to use some of it.

Q: Who can I contact if I have further questions?

A: Please contact Professor Liz Perkins, University of Liverpool, Eleanor Rathbone Building, 74 Bedford Street South, Liverpool, L69 7ZQ. Telephone Number 44 (0) 151 7945909. Email: e.perkins@liv.ac.uk

Q: Criminal Records Bureau check (CRB)

A: I have obtained a CRB Disclosure and you can request evidence of the Disclosure from the Principal Investigator (Liz Perkins).

Committee on Research Ethics

PARTICIPANT CONSENT FORM (child)

Title of Research Project: Children's' experiences of participating in trauma recovery and resilience building programmes

Researcher(s): Prof Elizabeth Perkins and Grace McGuire

Please
initial
box

1. I have read and have understood the information sheet dated [29/1/16] for the above study. I have had the opportunity to think about the information and ask questions about the study ☐
2. I understand that taking part is my choice and I can stop the talk at any time without giving any reason. I understand that I do not have to answer all the questions the researcher asks. ☐
3. I understand that, under the Data Protection Act, I can at any time ask for access to the information I provide and I can also ask that the information is destroyed. ☐
4. I understand that it will not be possible to identify me or anyone else in the write up of the study. ☐
5. I understand and agree that my talk with the researcher will be recorded. I am aware of and allow you to use these recordings so that you can type up our talk. ☐
6. I agree to take part in the above study. ☐

Participant Name (child)

Date

Signature

Name of Person taking consent

Date

Signature

Researcher

Date

Signature

Principal Investigator:

Name: Prof Elizabeth Perkins
Work Address: Eleanor Rathbone Building,
74 Bedford Street South
Liverpool L69 7ZA
Work Telephone: 0151 7945909
Work Email: e.perkins@liv.ac.uk

Student Researcher:

Name: Grace McGuire
Work Address: Eleanor Rathbone Building,
74 Bedford Street South
Liverpool L69 7ZQ
Work Email: g.mcguire@liv.ac.uk

Version 2: 29/1/16

Appendix 13: Example photographs of using post-it notes to develop themes

